SARCOA

Area Agency on Aging

DIRECT SERVICE PROVIDER

INFORMATION AND CONTRACTING PACKET

SARCOA, Area Agency on Aging, Region VII

1075 South Brannon Stand Road, Dothan, AL 36305

334-793-6843 or 1-800-239-3507 FAX 334-678-7564

Updated 2/16/2023

CHECKLIST

Return the following to SARCOA

(Please retain copies of all documents for your files)

_____ **Prospective Contractor Information Sheet**

_____ **Contractor Billing and Payment Authorization**

_____ **Signature Authorization for Billing Purposes**

_____ **Immigration Status Form**

_____ **Form W-9 (Federal Tax ID)**

_____ **Proof of current General and Professional Liability Insurance**

_____ **Proof of Workman's Compensation and Unemployment Insurance**

_____ **Copy of Business License**

_____ **Organizational Chart detailing all positions in your organizations**

_____ **Lines of Authority- List names and Responsibilities**

_____ **Provide a job description for each position in your organization**

_____ **List Names and License Numbers for all RN's and LPN's Employed; Licenses must be current/active/good standing**

_____ **Initial Orientation and Training Manuals**

_____ **Completed MW-25 (provided in packet) Orientation & Annual Training Form for each Waiver you intend to contract for**

_____ **Complaint and Grievance Policy (How you manage complaints/grievances)**

_____ **Complaint/Grievance Log w/ ability to describe the nature of the complaints and follow-up actions taken**

_____ **History of your Agency (ex. Initial date of operations, history of locations, and ownership leading up to this date)**

_____ **Map and written directions to your office location(s).**

_____ **Operating Budget (Predicted Annual Budget)**

_____ **Functioning Computer, Printer, and Internet Access (to be evaluated during office space review)**

_____ **Policy concerning Client/Patient confidentiality (HIPAA) and Employee Confidentiality Agreement**

_____ **A written Policy and Procedures Manual which includes hiring practices**

_____ **Agency's Emergency Plan regarding service delivery**

SARCOA Area Agency on Aging

1075 S. Brannon Stand/ DOTHAN, ALABAMA 36305

SIGNATURE AUTHORIZATION FOR BILLING PURPOSES

Please print or type.

***Contractor*:**
Address:
***Today's Date*:**

The following individuals have been authorized, in addition to myself, to sign Voucher Summary Sheets / Invoices billing the Southern Alabama Regional Council on Aging (SARCOA) for services rendered or purchases of goods under SARCOA programs. Persons not on this list will not be authorized to sign billing. Any billing submitted which is signed by someone other that those listed below (or on a subsequent Signature Authorization form) will be rejected.

Please print or type except where signatures are required.

Name	***Title***	***Official Signature***
This Authorization will continue through the following date:		

_____

Contractor Official Signature Date

_____

Title

Please notify SARCOA immediately if any of the above information changes. ***SARCOA-3-18-19***

IMMIGRATION STATUS

I do hereby attest and affirm that all workers in my business/agency/organization who are providing services in conjunction with a contract between my business/agency/organization and the Southern Alabama Regional Council on Aging (SARCOA), are either citizens of the United States or are in a proper and legal immigration status that authorizes them to be employed for pay within the United States of America.

_____

Signature of Contractor Representative Date

_____

Print Name of Representative

_____

Print Name of Agency

_____

Witness Date

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint.* You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

PROSPECTIVE CONTRACTOR INFORMATION SHEET

Agency Name: _____

Administrator: _____ Name of Owner: _____

Contact Person: _____ Phone Number: _____

Agency Phone Number: _____ FAX Number: _____

FEIN Number: _____ NPI Number: _____

Street Address: _____

_____

Mailing Address: _____

_____

E-mail Address: _____

Type of Agency: _____

Indicate (✔) all that apply:

- ☐ Sole Proprietorship
- ☐ Unincorporated
- ☐ Private Nonprofit
- ☐ Incorporated
- ☐ Faith Affiliated
- ☐ Governmental
- ☐ Private / Profit Making
- ☐ Public
- ☐ Other: _____

Indicate (✔) Funding Sources that apply:

- ☐ Medicare
- ☐ Medicaid
- ☐ Private Insurance
- ☐ Grants
- ☐ Private Pay
- ☐ Faith Funded
- ☐ Donations
- ☐ Dept. of Human Resources
- ☐ Dept. of Public Health
- ☐ Dept. of Mental Health
- ☐ Dept. of Rehabilitation
- ☐ Other: _____

Has there been a change in ownership or control within the last year? ☐ YES ☐ NO

If YES, Explain: _____

_____

_____

Do you anticipate filing bankruptcy within the year? ☐ YES ☐ NO

Do you anticipate expansion of the business within the year? ☐ YES ☐ NO

Is your agency operated by a management company, or leased in whole or part by another organization? ☐ YES ☐ NO If YES, Explain: _____

_____

Is your agency chain affiliated? ☐ YES ☐ NO If YES, list name and address:_____

_____

Are you the sole owner of your business or do you have a partner or financial backer?

☐ Yes ☐ No If yes, please list their name and contact information to include their phone number and email address: _____

_____

Do you have current liability insurance? ☐ YES ☐ NO

Do you have current worker compensation? ☐ YES ☐ NO

Do you have access to a computer? ☐ YES ☐ NO If YES, what programs do you have:

_____

What are your hours of operation? _____

I understand that supervision MUST be available during the hours of services being provided. ☐ YES ☐ NO

List regularly scheduled holidays: _____

_____

How do you manage phone calls after business hours? _____

_____

Do you provide services on: Weekends? ☐ YES ☐ NO, Holidays? ☐ YES ☐ NO, Nights? ☐ YES ☐ NO

How are patient complaints managed in your agency? (Please enclose your Complaints and Grievance Policy)

I propose (✔) to contract for the following service categories under the E&D, HIV/AIDS 530, or ACT Waiver programs*:

- ☐ Homemaker Services
- ☐ Personal Care
- ☐ Unskilled Respite Care
- ☐ Skilled Respite Care
- ☐ Companion Services
- ☐ Adult Day Health Care

***See Scopes of Services attached and also located on the SARCOA website for detailed services descriptions.**

I propose (✔) to provide services in the following counties of the state of Alabama:

- ☐ Barbour
- ☐ Coffee
- ☐ Covington
- ☐ Dale
- ☐ Geneva
- ☐ Henry
- ☐ Houston

List agencies with which you currently have certification, include dates of certification: _____

_____

List agencies with which you currently have accreditation, include dates of accreditation: _____

_____

Certification

I certify that all the statements made herein are true, accurate and correct. I understand that it is the contractor's responsibility to keep SARCOA informed of any changes in the above information or with the operation of the agency. I understand that falsification or information presented to SARCOA shall be grounds for immediate contract termination.

_____

Signature of Contractor Date

_____

Print name

_____

Title

SARCOA Area Agency On Aging

1075 S. Brannon Stand/ DOTHAN, ALABAMA 36305

CONTRACTOR BILLING & PAYMENT AUTHORIZATION

Authorization Period:
Contractor:

The Contractor shall furnish the following information concerning the person authorized to sign for the Contractor pertaining to financial matters related to contracts with the Southern Alabama Regional Council on Aging. *(Who will sign the billing?)*

Name:	***Official Signature:***
Title:	
Address:	
Telephone #:	

PAYEE: (Specify to whom payment shall be mailed.)

Name:
Title:
Address:

Contractor: _____
(Signature) *Date*

_____
(Title)

Notify SARCOA immediately if any of the above information changes. ***SARCOA-3-18-19***

TUBERCULIN SKIN TEST

No more than 90 days prior to employment, all staff having direct contact with clients shall have a PPD tuberculin skin test, unless a previously positive reaction can be documented. The two-step procedure is advisable for initial testing in those who are new employees in order to establish a reliable baseline. [If the reaction to the first test is classified as negative, a second test should be given a week later. If the second test is classified as negative, the person is considered as being uninfected. A positive reaction to a third test (with an increase of more than 10 mm) within the next few years, is likely to represent the occurrence of infection with M. Tuberculosis in the interval. If the reaction to the second of the initial two (2) tests is positive, this probably represents a boosted reaction, and the person should be considered as being infected.]

Employees with reactions of 10mm and over to the pre-employment tuberculin test, with newly converted skin test, and those with symptoms suggestive of tuberculosis (e.g., cough, weight loss, night sweats, fever, etc.) regardless of skin test status, shall be given a chest radiograph to determine whether tuberculosis disease is present. If tuberculosis is diagnosed, appropriate treatment should be given, and the person must not be allowed to work until declared non-contagious by a licensed physician.

Routine chest radiographs are not required on employees who are asymptomatic with negative tuberculin skin test. Employees with negative tuberculin skin tests shall have an annual tuberculin skin test.

New employees who have a history tuberculosis disease shall be required to have certification by a licensed physician or local health department TB staff (prior to employment and annually) that they are not contagious. Regular employees who are known or suspected to have tuberculosis shall be required to be evaluated by a licensed physician or local health department TB staff, and shall not return to work until they have been declared non-contagious.

Preventive treatment should be considered for all infected employees having direct contact who are skin test positive but show no symptoms of tuberculosis. Routine annual chest radiographs are not a substitute for preventive treatment. Employees who complete treatment, either for disease or infection, may be exempt from further routine radiographic screening, unless they develop symptoms of tuberculosis. Employees who do not complete adequate preventive therapy should have an annual assessment for symptoms of tuberculosis.

For additional information contact: Tuberculosis Control Division, Alabama Department of Public Health, The RSA Tower, Suite 1450, 201 Monroe Street, P.O. Box 303017, Montgomery, Al 36130-3017; 334-206-5226.

KAY IVEY
GOVERNOR

STATE OF ALABAMA
DEPARTMENT OF SENIOR SERVICES

RSA Tower Suite 350
201 Monroe Street
P.O. Box 301851
MONTGOMERY, AL 36130-1851

JEAN W. BROWN
COMMISSIONER

(334) 242-5743
FAX: (334) 242-5594
www.alabamaageline.gov

December 19, 2022

LTC Notice 22-04

TO: Area Agencies on Aging Directors

FROM: Jean Stone, Assistant Commissioner
Medicaid Waiver Programs

SUBJECT: **Background Check Policy for the Waiver Programs**

EFFECTIVE: October 1, 2022

The language below will be added to the ADSS Long Term Care Policy and Procedure Manual as a revised section for Part 8, Section 8.5 regarding Background Checks, and the new requirement for a nationwide check. **Providers and AAAs will have until January 31, 2023, to complete National Checks on staff hired since October 1,2022.** All new staff moving forward should have the National Check prior to hire. Please provide a copy of this to your Direct Service Providers and your Case Managers.

Section 8.5: Background Checks

Effective October 1,2022, background checks must be conducted on a nationwide basis. The National background check shall consist of the following personal identifiers: name, social security number, date of birth, driver's license number and/or applicable state identification card (i.e. nondriver's identification). Additionally, the authorized background check agency shall notify the potential employer if the background check reveals that an applicant is listed in the national sex offender public registry. Any services performed by a person in violation of the background checks are to be considered an overpayment and are recoupable.

The following criminal activities that will permanently disqualify a potential applicant from employment:
Applicants must not have convictions or pending charges for:

- Any crime of violence
- Any felony convictions as well as any pending felony arrests

The following are criminal convictions that would prevent an individual from being employed for the time period as specified below:

- Reckless endangerment in the past 5 years
- Stalking in the second degree in the past 5 years

- Criminal trespass in the first degree in the past 5 years
- Violating a protective order in the past 3 years
- Unlawful contact in the first degree in the past 3 years
- Criminal mischief in the first degree in the past 7 years
- Unlawful contact in the second degree in the past year

The following are the specifics related to the background checks:

- Statewide background checks are required for employees hired on or after October 1, 2007, and Nationwide background checks for those hired on or after October 1,2022.
- All background checks must be performed **prior** to the date of hire.
- Employees are not allowed to provide services until after the results of the background check have been received.
- Statewide background checks are not required for employees hired prior to October 1, 2007. Nationwide background checks are not required for those hired before October 1,2022.
- Nationwide background checks are required for all DSPs and for any employee who operates within the state of Alabama and has access to client records.
- Out-of-state corporate office employees are not required to have a background check completed.
- Case Managers, Adult Day Health, and Home Delivered Meals providers are also required to undergo a background check.
- DSPs are responsible for conducting monthly checks of employees against the Medicaid Exclusion List.
- If an employee is terminated/leaves employment of the DSP and then is re-hired, a new background check must be obtained.
- Verification of the performance of background checks will be conducted during audit reviews.
- Failure to perform all components of the background check will result in recoupment of funds paid for services provided by the employee.

In addition to the background check, employers must also check the State of Alabama Nurse Aide Registry and previous employer references. DSPs are also required to check the OIG/Medicaid Exclusion List initially and on a monthly basis.

Procedure to Search Alabama Certified Nurse Aide Registry

The supervisor will conduct the background check regarding the Alabama Certified Nurse Aide Registry by taking the following action:

- Access the Alabama Certified Nurse Aide Registry website at http://www.adph.org/. Click on Contents A-Z, and then click on Nurse Aide Registry.
- Two (2) questions will come up. Select: Visit the Alabama Certified CNA Registry.
- Enter the applicant's social security number (SSN) in the appropriate boxes and click on the "Search" button.
- Verify the status of the applicant.
- If the applicant is not listed in the Nurse Aide Registry, a message will appear to indicate the SSN entered is "not found in registry."
- If the applicant is certified as a nurse aide and is in good standing, the Status will indicate "In Good Standing."
- If the applicant is certified as a nurse aide and has been convicted of abuse, the Status will indicate there is important additional information concerning this individual and give instruction to click on the "Request More Info" button to submit a request for more information or call 334-206-5169.

  *Note: There are reasons other than convictions for abuse that may trigger this message, so contact the appropriate personnel in the Bureau of Health Provider Standards to verify Nurse Aide Registry listing.

- Print the results page from the website.
- If it is determined that the applicant is either not listed or is a Nurse Aide in good standing on the Nurse Aide Registry, the interview of the applicant can proceed.
- If it is determined that the potential applicant is listed on the Nurse Aide Registry and has been convicted of abuse, the applicant is not eligible for hire in the HCBS Waivers Medicaid Program.

*FYI: Can click on Abuse List at the top of the page to view names on this list.

PUBLIC HEALTH
Health Provider Standards

Alabama Department of Public Health
Certified Nurse Aide Registry

ADPH

Alabama Certified Nurse Aide Registry

Get Adobe Reader You will need the FREE Adobe Reader to print the Nurse Aide Status Report or to view the Abuse List.

Search the Alabama Certified Nurse Aide Registry to verify the status of a Nurse Aide.

Social Security Number [ ] - [ ] - [ ] Search

XXX-XX-7590 is not found in registry.

Procedure(s) to Search National Sex Offender Public Registry

The Supervisor will conduct a background check regarding the applicant's sex offender status by taking the following steps:

- Access the National Sex Offender Public Registry at http://www.nsopr.gov/ to determine if the applicant is listed.
- After reading the Conditions of Use, click on the "I agree" button.
- Enter the code provided in the appropriate box and click on the "Continue" button.
- Enter the applicant's Last Name and First Name or Initial in the appropriate boxes.
- Click on the "Search" button. When results appear, to verify al list of jurisdiction included in search, "click here". A list will come up showing all states queried.
- Print the "Search Results" page from the website.
- If it is determined that the applicant is not listed in the National Sex Offender Public Registry, the interview of the applicant can proceed.
- If it is determined that the potential applicant is listed in the National Sex Offender Public Registry, then the applicant is not eligible for hire in the HCBS Waivers Medicaid Program.

National Sex Offender Search Results

0 records from a national search including all states, territories and Indian Country for First Name like ***victoria***, Last Name like ***edwards***

Search performed 10/3/2014 10:51 AM EDT

Exclusions Search Results: Individuals

No Results were found for

edwards , victoria

edwards , timothy

edwards , margaret

hassell , mary

harrison , mark

If no results are found, this individual or entity (if it is an entity search) is not currently excluded. Print this Web page for your documentation

Search Again

Search conducted 10/3/2014 11:13:42 AM EST on OIG LEIE Exclusions database.
Source data updated on 9/9/2014 9:15:00 AM EST.

Links to Data Bases:

http://www.medicaid.alabama.gov/CONTENT/7.0_Fraud_Abuse/7.7_Suspended_Providers.aspx

http://exclusions.oig.hhs.gov/

http://www.nsopr.gov/

https://ph.state.al.us/NurseAideRegistry/(S(dimakv55yn2eig55fbhke53l))/Default.aspx

Alabama Department of Senior Services Medicaid Waiver Programs

DSP Quality Performance Assessment

(Personnel File Review)

Name of Staff Member	Job Title of Staff Member	Hire Date of Staff Member	Audit Date

Name of Direct Service Provider	Name and Agency of Reviewer

(The below section applies to ALL in-home workers. Also complete the section that pertains to the type of service provided by the worker.)

Staff member's first access to client information or client contact?			DATE:
A copy of the staff member's job description is present in the employee's file (should identify responsibilities, education and experience)?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member's personnel file contains documentation that references were verified **for those hired prior to 10/01/07)**	☐ Yes ☐ No ☐ N/A Date conducted:	Comments	
Staff members and all personnel with access to client information have proof that **statewide criminal background checks** are documented in the employee's personnel file and are prior to hire? (This pertains to employees hired as of 10/01/16.)	☐ Yes ☐ No ☐ N/A Date conducted:	Comments	
Staff members and all personnel with access to client information have proof that **sex offender checks** are documented in the employee's personnel file and are prior to hire? (This pertains to employees hired as of 10/1/16.)	☐ Yes ☐ No ☐ N/A Date conducted:	Comments	
Staff members and all personnel with access to client information have proof that **nurse aide registry checks** are documented in the employee's personnel file and are prior to hire? (This pertains to employees hired as of 10/01/16.)	☐ Yes ☐ No ☐ N/A Date conducted:	Comments	
Staff members and all personnel with access to client information have proof that **previous employers and references are verified** and documented in the employee's personnel file and are prior to hire? (This pertains to employees hired as of 10/01/16.) (Excludes owner)	☐ Yes ☐ No ☐ N/A Date conducted:	Comments	
Initial- Staff member's file contains documentation that he/she submits to a program for the testing, prevention, and control of tuberculosis. Effective for employees hired as of 12/1/2019, did the employee receive a TB test and screening prior to client contact?	☐ Yes ☐ No ☐ N/A Dates:	Comments	TB Skin Test Date: TB Screening Date:
Annual- Has the employee received annual training/education? For employees hired prior to 12/1/2019 was their TB training/education given by the annual due date of their last TB test? Dates of last 2 trainings/education.	☐ Yes ☐ No ☐ N/A Dates:		Education Date: Education Date:
Staff member's personnel file contains an application for employment. (excludes owner)	☐ Yes ☐ No ☐ N/A	Comments	
Staff member's personnel file contains a record of pre-employment?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member's personnel file contains evaluations per each agency policy?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member's personnel file contains a copy of a valid, government issued, picture identification?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member meets orientation training requirements prior to service delivery.	☐ Yes ☐ No ☐ N/A	Comments	
Staff member meets annual in-service training requirements. (These must include infection control updates as well as abuse, neglect, and exploitation. A four (4) hour annual limit for self-study i.e. videos/online is in effect.)	☐ Yes ☐ No ☐ N/A	Comments	Previous year's hours: Current year's hours:
Staff member's file contains other forms as required by state and federal law including agreements regarding confidentiality?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member's file contains an every six (6) month direct supervisory visit?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member's file contains records of all complaints/incidents lodged by the client/family and action taken?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member's file contains documentation of education (high school diploma or equivalent) (supervisor only)? (HM & CO)	☐ Yes ☐ No ☐ N/A	Comments	
RN/LPN has a current Alabama State Board of Nursing license? (PC & SR) (530 Waiver, SN/RN or LPN)	☐ Yes ☐ No ☐ N/A	Comments	
RN/LPN supervisor has two (2) years (preferable) experience as a Registered Nurse or Licensed Practical Nurse? (PC & SR) (530 Waiver, SN/RN or SN/LPN)	☐ Yes ☐ No ☐ N/A	Comments	

Alabama Department of Senior Services Medicaid Waiver Programs

DSP Quality Performance Assessment

(In-Home Worker Training Requirements)

Name of Staff Member

ADDITIONAL HOMEMAKER & UNSKILLED RESPITE (HM) REQUIREMENTS

Minimum training requirements for Homemaker prior to service delivery include all of below items. The annual in-service training is in addition to the training required prior to the provision of service. ALL Homemakers must have at least six (6) hours, in-service training annually from the following areas below and include topic, name and title of trainer, objective of training, date of training, outline of content, length of training, list of trainees and location. (O) = Orientation Training Requirements (A) = Annual Training Requirements

(O)	(A)	
☐	☐	Physical, emotional and developmental needs of population served including the need for respect of the client, his/her privacy, and his/her property.
☐	☐	Maintaining a safe and clean environment;
☐	☐	Providing care including individual safety, laundry, serve and prepare meals, and household management;
☐	☐	First aid in emergency situations;
☐	☐	Fire and safety measures;
☐	☐	Client rights;
☐	☐	Record keeping such as a signed service log of services delivered and a written summary to supervisor of any problems with services;
☐	☐	Communication skills;
☐	☐	Basic infection control/Universal Standards;
☐	☐	Abuse, neglect, mistreatment, and exploitation.

ADDITIONAL PERSONAL CARE & UNSKILLED RESPITE (PC) REQUIREMENTS

Unskilled Respite Workers must meet the same orientation and in-service training requirements as a HM and PCW dependent upon the level of care. Minimum training requirements for Personal Care prior to service delivery include all of the below items. The annual in-service training is in addition to the training required prior to the provision of service. ALL PC and UR Workers must have at least twelve (12) hours, in-service training annually from the following areas below and include topic, name and title of trainer, objective of training, date of training, outline of content, length of training, list of trainees and location (For PC Workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a PC Worker.)

(O)	(A)	
☐	☐	Physical, emotional and developmental needs of population served including the need for respect of the client, his/her privacy, and his/her property.

Activities of daily living, such as,

☐	☐	Bathing (sponge, tub)
☐	☐	Personal grooming
☐	☐	Personal hygiene
☐	☐	Meal preparation
☐	☐	Proper transfer technique (assisting clients in and out of bed)
☐	☐	Assistance with ambulation
☐	☐	Toileting
☐	☐	Feeding the client

Home support, such as,

☐	☐	Cleaning
☐	☐	Laundry
☐	☐	Home safety

Recognizing and reporting observations of the client, such as,

☐	☐	Physical condition
☐	☐	Mental condition
☐	☐	Emotional condition
☐	☐	Prompting the client of medication regimen

Plus,

☐	☐	Record keeping such as a signed service log of services delivered and a written summary to supervisor of any problems with services
☐	☐	Communication skills
☐	☐	Basic infection control/Universal Standards
☐	☐	First aid in emergency situations
☐	☐	Fire and safety measures
☐	☐	Client rights and responsibilities
☐	☐	Abuse, neglect, mistreatment, and exploitation.

Alabama Department of Senior Services Medicaid Waiver Programs

DSP Quality Performance Assessment

(In-Home Worker Training Requirements)

Name of Staff Member

ADDITIONAL COMPANION REQUIREMENTS

Minimum training requirements for Companion prior to service delivery include all of the items below. The annual in-service training is in addition to the training required prior to the provision of service. ALL Companion Workers must have at least six (6) hours, in-service training annually from the following areas below and include topic, name and title of trainer, objective of training, date of training, outline of content, length of training, list of trainees and location.

(O)	(A)	
☐	☐	**Physical, emotional and developmental needs of population served including the need for respect of the client, his/her privacy, and his/her property.**
☐	☐	**Meal planning and preparation;**
☐	☐	**Laundry/shopping;**
☐	☐	**Provision of care and supervision including individual safety;**
☐	☐	**First aid in emergency situations;**
☐	☐	**Documentation of services provided per written instructions;**
☐	☐	**Basic infection control/Universal Standards (required annually);**
☐	☐	**Fire and safety measures;**
☐	☐	**Assist clients with medications;**
☐	☐	**Communication skills;**
☐	☐	**Client rights;**
☐	☐	**Abuse, neglect, mistreatment, and exploitation.**

ADDITIONAL SKILLED RESPITE CARE REQUIREMENTS

SKILLED RESPITE WORKER - AND SKILLED NURSING WORKER (E&D, ACT or 530 Waiver) A Licensed Practical Nurse (LPN) or Registered Nurse (RN) who meets the following additional requirements:

(O)	(A)	
☐	☐	**Be currently licensed by the State of Alabama Board of Nursing to practice nursing.**
☐	☐	**Have at least two (2) years of experience (preferable).**
☐	☐	**The personnel file contains documents that the nurse submits to the program for testing, prevention, and control of tuberculosis annually.**
☐	☐	**Be able to follow the Plan of Care with minimal supervision unless there is a change in the client's condition.**
☐	☐	**The personnel file contains a copy of a valid, picture identification.**
☐	☐	**The personnel file contains validation of CEUs for licensure.**
☐	☐	**The DSP must assure Medicaid and the Operating Agency (OA) that the nurse has adequate experience and expertise to perform the skilled services and the care required.**

Additional Comments

Alabama Department of Senior Services Medicaid Waiver Programs

DSP Quality Performance Assessment

(Client File Review)

Name of Client	Medicaid Number	Name of Case Manager	Audit Date

Name of Direct Service Provider Agency	Frequency/Service(s) Authorized

Name and Agency of Reviewer	Period of Review

Both current and historical "Service Provider Authorization" form(s) is/are present in the client file?	☐ Yes ☐ No ☐ N/A	Comments	
The Service Provider Authorization Form contains the number of units, frequency, begin date, and activities to be performed?	☐ Yes ☐ No ☐ N/A	Comments	
Services were initiated within three (3) working days of the designated "START DATE" on the Service Authorization Form? (Per 10/01/07 waiver renewal). Prior to 10/01/07 within three (3) days of "receipt" of the service authorization.	☐ Yes ☐ No ☐ N/A	Comments	
Were services started prior to the start date on the Service Authorization Form?	☐ Yes ☐ No ☐ N/A	Comments	
Were services billed prior to the start date on the Service Authorization Form?	☐ Yes ☐ No ☐ N/A	Comments	
The file contains a "new" Service Authorization Form for any change in number of hours, frequency, or type of service?	☐ Yes ☐ No ☐ N/A	Comments	
The file contains a Service Authorization Form to terminate services? (If applicable).	☐ Yes ☐ No ☐ N/A	Comments	
During the initial assessment, is there evidence that the provider reviewed the Care Plan, reviewed and provided written information regarding rights and responsibilities, discussed how to register complaints, discussed the provisions and supervision of the service(s) and left appropriate phone numbers with the client and/or caregiver? (As of 05/01/2008).	☐ Yes ☐ No ☐ N/A	Comments	
The file contains all 60 day supervisory reports and they are within the required time frame?	☐ Yes ☐ No ☐ N/A	Comments	
If the supervisory visit wasn't completed in a timely manner, **due to the client being inaccessible**, was it completed within five (5) working days?	☐ Yes ☐ No ☐ N/A	Comments	
The supervisory visit report includes assurances that the services are being delivered consistent with the Plan of Care and the Service Authorization Form in an appropriate manner?	☐ Yes ☐ No ☐ N/A	Comments	
The supervisory visit report includes assurances that the client's needs are being met, and includes a brief statement regarding the client's condition?	☐ Yes ☐ No ☐ N/A	Comments	
The summary is submitted to the case manager within ten (10) calendar days of submission of the supervisory report?	☐ Yes ☐ No ☐ N/A	Comments	
The file contains documentation of an initial visit for in-home services prior to service implementation?	☐ Yes ☐ No ☐ N/A	Comments	
The initial visit included the case manager, worker, worker supervisor, and the client/caregiver?	☐ Yes ☐ No ☐ N/A	Comments	
A complete/current copy of the HCBS application (to include the Plan of Care) is present in the client/patient file?	☐ Yes ☐ No ☐ N/A	Comments	
Does the file indicate that the client had a change in condition or the Plan of Care no longer meets the client's needs?	☐ Yes ☐ No ☐ N/A	Comments	
Did the DSP notify the case manager within one (1) working day of any change in the client's condition?	☐ Yes ☐ No ☐ N/A	Comments	
Did the case manager respond back to the DSP within one (1) working day of the DSP's notification?	☐ Yes ☐ No ☐ N/A	Comments	
A record of all complaints lodged by the client, family member or responsible party, and any action taken, is in the client/patient file, and followed up on per AMA requirements?	☐ Yes ☐ No ☐ N/A	Comments	

Name of Client	Medicaid Number

The case manager was notified by telephone immediately, if services could not be provided to an "at risk" client?	☐ Yes ☐ No ☐ N/A	Comments	
The file contains all service logs (signed by the client, family member/responsible party and the worker)?	☐ Yes ☐ No ☐ N/A	Comments	
If the service logs are not signed, did the worker document why they were not signed?	☐ Yes ☐ No ☐ N/A	Comments	
The service logs are reviewed and signed by the supervisor every two (2) weeks? (PC, HM, CO)	☐ Yes ☐ No ☐ N/A	Comments	
All missed/attempted visits are documented and sent to the case manager weekly (Monday) as required?	☐ Yes ☐ No ☐ N/A	Comments	
The case manager was notified within one (1) working day after the second attempted visit whenever two (2) attempted visits occur within the SAME week?	☐ Yes ☐ No ☐ N/A	Comments	
If Skilled Respite service is provided, did the worker fully document that the services were authorized by the client's physician and performed for the client during "each" visit?	☐ Yes ☐ No ☐ N/A	Comments	
If respite, Skilled or Unskilled is provided, were the service logs and documentation forms signed by the respective supervisor at least once every two (2) weeks? For 530 Waiver also SN/RN or LPN?	☐ Yes ☐ No ☐ N/A	Comments	
If Personal Assistance (Support) Services are provided, did the worker fully document that the services were authorized by the client's physician and performed for the client for at least 40 hours per month?	☐ Yes ☐ No ☐ N/A	Comments	
If Assistive Technology is used is there documentation to support medical necessity?	☐ Yes ☐ No ☐ N/A	Comments	
The billing corresponds with the service logs?	☐ Yes ☐ No ☐ N/A	Comments	
The billing corresponds with the missed visit reports?	☐ Yes ☐ No ☐ N/A	Comments	
The services billed match the services authorized?	☐ Yes ☐ No ☐ N/A	Comments	

Additional Comments

Alabama Department of Senior Services Medicaid Waiver Programs

DSP Quality Performance Assessment

(Administrative Review)

Name of Direct Service Provider Agency	Name and Agency of Reviewer	Audit Date

The DSP has designated an individual to serve as the agency administrator?	☐ Yes ☐ No ☐ N/A	Comments	
The DSP agency has key staff, to include the agency administrator or DSP supervisor, present during this compliance audit?	☐ Yes ☐ No ☐ N/A	Comments	
The DSP supervisor is immediately assessable by phone?	☐ Yes ☐ No ☐ N/A	Comments	
The DSP has an organizational chart showing chain of command and it is accessible to the staff?	☐ Yes ☐ No ☐ N/A	Comments	
The DSP has a written policy on infection control procedures, and an ongoing infection control program in place?	☐ Yes ☐ No ☐ N/A	Comments	
The DSP has a written policy concerning client/patient confidentiality (HIPAA) and all files are locked up?	☐ Yes ☐ No ☐ N/A	Comments	
The DSP has a written client/patient complaint and grievance policy and procedure?	☐ Yes ☐ No ☐ N/A	Comments	
The DSP has some type of complaint log and a means of monitoring/conducting complaints received including follow up?	☐ Yes ☐ No ☐ N/A	Comments	
Is the DSP in-service training pre-approved by the Operating Agency and Medicaid?	☐ Yes ☐ No ☐ N/A	Comments	
The DSP had a change in agency administrator, address or phone number?	☐ Yes ☐ No ☐ N/A	Comments	
If there was a change in administrator, address or phone number, was the Operating Agency notified?	☐ Yes ☐ No ☐ N/A	Comments	
The DSP has an office open during normal business hours?	☐ Yes ☐ No ☐ N/A	Comments	
The DSP has a list of regular scheduled holidays (office can not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend)?	☐ Yes ☐ No ☐ N/A	Comments	
The DSP has current liability insurance?	☐ Yes ☐ No ☐ N/A	Comments	
The DSP has a written Policy and Procedures Manual which includes hiring practices?	☐ Yes ☐ No ☐ N/A	Comments	
The DSP's Policy and Procedures Manual includes the agency's Emergency Plan regarding service delivery?	☐ Yes ☐ No ☐ N/A	Comments	
The DSP has an operating annual budget?	☐ Yes ☐ No ☐ N/A	Comments	
The DSP has an appropriate place of business/office?	☐ Yes ☐ No ☐ N/A	Comments	

Additional Comments

Alabama Department of Senior Services Medicaid Waiver Programs

Direct Service Providers Orientation Training Approval List

DSP Name_____ **Calendar Year** _____

To be completed by the contracting Direct Service Provider:

Signature of person completing the form: _____

Title: _____ Date of Completion_____

Please indicate the employees who will receive the training listed below:

Homemakers☐ Personal Care Workers☐ Companion Workers☐
Adult Day Health Workers☐ Unskilled Respite Workers☐ RN☐ LPN☐

Please indicate which Waiver employees will receive the training listed below:

Elderly and Disabled Waiver (E&D)☐ Alabama Community Transitions Waiver (ACT)☐

Topic	Name/Title of Trainer	Objectives	Outline of Contents	Length

To be completed by the contracting Area Agency:

The training, as listed, is approved for calendar year _____. Date: _____

Signature: _____ Title: _____

cc: QA Auditor, ADSS

Alabama Department of Senior Services Medicaid Waiver Programs

Direct Service Providers
Annual Training Approval List

DSP Name_____ **Calendar Year** _____

To be completed by the contracting Direct Service Provider:

Signature of person completing the form: _____

Title: _____ Date of Completion_____

Please indicate the employees who will receive the training listed below:

Homemakers☐ Personal Care Workers☐ Companion Workers☐
Adult Day Health Workers☐ Unskilled Respite Workers☐ RN☐ LPN☐

Please indicate which Waiver employees will receive the training listed below:

Elderly and Disabled Waiver (E&D)☐ Alabama Community Transitions Waiver (ACT)☐

Topic	Name/Title of Trainer	Objectives	Outline of Contents	Length

To be completed by the contracting Area Agency:

The training, as listed, is approved for calendar year _____. Date: _____

Signature: _____ Title: _____

cc: QA Auditor, ADSS

MW-25B 9/2017R

THE ALABAMA DEPARTMENT OF SENIOR SERVICES LONG TERM CARE POLICY AND PROCEDURE GUIDE

January 2017

Table of Contents

Part 1: Roles and Responsibilities

Section 1.1: The Centers for Medicare and Medicaid Services (CMS)

Medicaid home and community-based services (HCBS) are federally approved waiver programs available to individuals who meet the required Medicaid-covered level of care provided in a nursing facility, skilled nursing facility, and intermediate care facility for individuals with an intellectual disability, or hospital. The amount, scope, and duration of the waiver programs are limited to what has been approved by the federal government.

Individuals must have a need for assistance with activities of daily living or need assistance due to their inability to function independently in their home or community-related to their disability or age. Once the applicant requests services through the HCBS waiver, a case manager will be assigned to assist in the assessment of the needs of the member, identify what services can meet the member's needs, identify who can provide the services, and the amount of services, and cost of services.

If a member selects home and community-based services, the provision of these services must be based on the assessed service needs of the member and services must be available to meet their needs. ADSS requires advance approval for services. The services must also be cost-effective and least costly to meet the needs of the member. Payment will only be made to eligible and enrolled Medicaid HCBS waiver providers. All services and providers must be identified in the service plan for each member accessing waiver services. A nurse reviewer at ADSS must approve the service plan prior to enrollment in the program.

Section 2176 of OBRA amended the Social Security Act to create the waiver program. The purpose and intent of a Medicaid waiver is stated in Section 1902(c) of the Social Security Act.

The legal basis for Medicaid home and community-based service waivers is found in Section 1915(c) of the Social Security Act. Public Law 97-35, the Omnibus Budget Reconciliation Act (OBRA) of 1981, contained provisions allowing states to request waivers to provide cost-effective home and community-based services to eligible people so they can avoid or leave institutionalization.

The OBRA of 1987 established that people residing in nursing homes who meet assessment criteria for specialized services can access waiver programs.

The portions of the Code of Federal Regulations specifically dealing with home and community-based services are in Title 42, Parts 431.50, 435.3, 435.217, 435.726, 435.735, 440.1, 440.180, 440.250, 441.300 through 441.306, and 441.310. These regulations specify the requirements that the state must meet to be eligible for federal financial participation and, in addition to the Social Security Act, serve as the basis for state law and administrative rules.

Alabama Medicaid Agency (AMA) was granted a three-year waiver effective October 1, 1984, by the Centers for Medicare and Medicaid Services (CMS) (formerly Health Care Financing Administration – HCFA) of the Department of Health and Human Services, to offer home and community based services under Title XIX of the Older Americans Act. Alabama's waiver was renewed for additional five-year periods beginning October 1, 1987, 1992, 1997, 2002, 2007, and in 2012. Additional information about HCFA/CMS can be found at https://www.cms.gov/About-CMS/Agency-Information/History/index.html.

All HCBS waivers are operated by a designated state agency; Alabama Department of Mental Health (ADMH), Alabama Department of Rehabilitation Services (ADRS), and Alabama Department of Senior Services (ADSS). The Operating Agency (OA) has the authority for the operation of the waiver programs including prior authorization of waiver services and determination of level of care.

There are currently seven HCBS waivers that include:

- AIDS/HIV (530)
- Alabama Community Transition (ACT)
- Elderly and Disabled Waiver (EDW)
- Intellectual disability (ID)
- Living at Home Waiver (LAH)
- State of Alabama Independent Living (SAIL)
- Technology Assisted Waiver (TAW)

Section 1.2: Alabama Medicaid Agency (AMA)

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. All Home and Community Based Services Waivers are administered by the Long Term Care Health Care Reform Division of AMA. ADSS is designated OA for the 530 Waiver, ACT Waiver, EDW, and TAW. ADRS is the designated OA for the SAIL Waiver; ADMH is the designated OA for the ID Waiver and the LAH Waiver. AMA exercises administrative discretion in the management and supervision of the waiver and issues policies, rules and regulations related to the waiver. AMA assumes the responsibility of:

- Conducting joint trainings with Direct Service Providers (DSPs) enrolled to provide services through the ACT Waiver;
- Providing periodic training to discuss policies and procedures in an effort to consistently interpret and apply policies related to the ACT Waiver program, which are outlined in the ACT Waiver manual;
- Conducts annual training to disseminate policies, rules and regulations regarding the home and community based waiver programs.

AMA has developed a Quality Management Strategy for Waiver programs. The following activities are components of the Quality Assurance Strategy:

- Collect ongoing monthly data to monitor appropriateness of level of care determinations;
- Collect quarterly data from registered nurses by any of the following sources: reviewing a sample of the waiver case management records, DSP records, conducting on-site visits to participant's homes, conduct consumer satisfaction surveys, and tracking complaints and grievances;
- Ensure that remediation for non-compliance issues and complaints identified during data collection are handled by requesting the entity involved to submit a plan of correction; and
- Collect data and submit quarterly and annual reports to the OA staff for evaluation and recommendations for program improvements. AMA LTC Division mails satisfaction surveys to clients on a quarterly basis, and tracks any complaints and/or grievances that are received.

AMA conducts quarterly meetings with the operating agencies (OA)to discuss issues and concerns in an effort to ensure provides are following and applying federal and state guidelines in accordance with the approved waiver documents.

Section 1.3: Alabama Department of Senior Services (ADSS)

ADSS is a cabinet level state agency that administers programs for senior citizens and people with disabilities. The department (formerly the Alabama Commission on Aging) was originally established by the Alabama Legislature in 1957 as the Alabama Commission on Aging. ADSS was established under Title 38 Chapter 3 of the Code of Alabama.

AMA has appointed ADSS as the OA for the following waivers:

- AIDS/HIV (530) effective 2012
- Alabama Community Transition (ACT) effective April 1, 2015
- Elderly and Disabled Waiver (EDW) effective 2000
- Technology Assisted Waiver (TAW) effective April 1, 2015

AMA agreed to designate ADSS, as its agent to be responsible for client assessment, evaluation and reassessment conducted by appropriate professionals as specified in the Waiver. ADSS agreed to implement and maintain such services and procedures, as are necessary to the proper and orderly administration of the assigned Alabama Medicaid HCBS Waiver programs within the guidelines and regulations established by AMA and CMS. The Alabama Department of Rehabilitation and the Alabama Department of Mental Health have comparable agreements with AMA for other HCBS Waivers.

Section 1.4: Area Agency on Aging (AAA)

ADSS contracts with 13 Area Agencies on Aging (AAAs), Councils of Local Governments (COG's) and/or Regional Planning Commissions (RPCs) to provide case management and perform the local activities necessary to fulfill the objectives of the program.

Provision of Section 307(a) (10) of the Older Americans Act has been waived by ADSS to allow the provision of the direct service of case management by AAAs. All other services under HCBS waiver programs will be provided by eligible contractors/providers selected by the ADSS or the AAA/COG/RPC's.

Section 1.5: Direct Service Provider (DSP)

Contracts for the delivery of HCBS Waiver Services may be negotiated without the bid process. An AAA/COG/RPC is required to contract with more than one provider for the delivery of a particular service (if possible) to ensure the client has "freedom of choice".

All providers of services for the E&D waiver program must comply with any applicable state and/or federal licensing or certification standards, policies and procedures. Medicaid Agency staff or their designee will accredit facilities as necessary in accordance with specified waiver requirements. In approving a facility for participation, the agency shall consider the qualifications of direct service personnel, administrative capability, adequacy of the physical plant and equipment and the appropriateness of services.

The Waiver states that personal care must be provided by a certified home health agency. However, in those cases that a non-certified agency can provide care of better quality or at a lower rate, the AAA/COG/RPC may request an exemption from this requirement by composing a letter documenting the circumstances to the Commissioner of AMA, including assurances that the standards of services and personnel as specified in the Waiver will be upheld. The letter should be sent to ADSS. The letter will be reviewed, have a cover letter attached, and then be forwarded to Medicaid for approval.

The exemption to contract with a non-certified agency for personal care services is only valid for a period of one year and must be re-approved by AMA at the beginning of each Fiscal Year.

Part 2: Provider Information

Section 2.1: Approval Process

All Prospective Direct Service Providers (PDSPs) must undergo an onsite review/audit in order in order to be considered as a provider of service. It must be determined that all waiver requirements for participation are met prior to an approval being granted.

It is a requirement that all providers under contract be assessed on an annual basis to determine that all contractual agreements are being fulfilled. The audit process is discussed in Part 9. The audit documents are contained in Appendix C.

Section 2.2: Requirements for Participation

All providers of service must have a written contractual agreement with the AAA or entity managing the waiver program.

Providers are required to maintain records for each individual they serve and the record must contain all pertinent information to include assessments and POC. The records are to be kept for at least five years following the termination of waiver services.

Providers may limit the number of Medicaid recipients they are willing to serve; however, they may not discriminate in selecting the Medicaid recipients they will serve.

Section 2.3: Requirements for all Providers (excluding Case Management)

All Waiver Service providers must meet the general requirements outlined in within the approved Medicaid Waiver document to gain approval and to remain in approved status. The requirements address the following categories:

- Policy and Procedure manuals
- Insurance Coverage
- Organizational Chart
- Proof of Managerial Ability

General administrative requirements for providers include, but are not limited to;

- Compliance with Waiver requirements to include quality control and quality assurance
- Financial status for providers documenting financial stability and ability to manage fiscal responsibilities
- Professional qualifications and requirements to include the ability to meet requirements for qualified personnel and training.

Please review **ADSS's Prospective Direct Service Provider Audit Protocols** in Part 9 for information on what providers are required to have in place prior to offering services to consumers. Requirements vary to some extent depending on the specific services applicants wish to be approved to provide and/or the waiver for which the applicant wishes to provide services.

Section 2.4: Provider Re-Approval

ADSS routinely reviews the performance of all of its Medicaid HCBS Waiver providers and makes re-approval determinations annually.

Section 2.5: Claims and Billing

The AAA should submit billing to ADSS to the attention of Ms. Shannon Shaw and cc: Ms. Lindsey Raughton on the Tuesday prior to the Friday check write date by 12:00 p.m. The billing may be submitted Facsimile or Email and signed by the appropriate staff person. The original copy is to be sent in by United States Postal Service. The billing will be processed on Wednesday before the check write date. The check write dates are established by AMA and can be found on their website. Should a AAA's billing not be received in a timely manner prior to the check write date deadline, it will be processed on the next check write date.

Section 2.6: Direct Service Provider Termination Procedure

If a AAA terminates a DSP or the provider closes the business, all waiver clients receiving services from the provider are to be notified of the effective date of closure. The clients are to be given Freedom of Choice(FOC) in selecting a new provider. A copy of the FOC form must be forwarded to ADSS along with a copy of the termination letter. ADSS will submit the documentation to Medicaid to support that the client was afforded freedom of choice in selecting a new provider.

The client may elect to wait to begin services under the new provider at the effective date. If the client wishes, they may change to the new provider immediately. In the event the DSP is being terminated due to health/safety reasons, the clients will be moved immediately to a new provider. If the move happens immediately, and/or there is a large volume of clients affected, the initial visit with the new DSP may be waived with approval from ADSS.

Part 3: Additional Medicaid Information

Section 3.1: State Plan Medicaid

Clients who are eligible for Medicaid Waiver Services may also qualify for other Medicaid benefits as authorized through the state plan. Individuals may request the "Medicaid Covered Services" Handbook from AMA to access information regarding other services provided.

Section 3.2: Home Health Services

Home health care services are available to all Medicaid-eligible persons of any age, who meet the admission eligibility criteria and whose medical, nursing, and social needs can adequately be met in their home. In order to meet the eligibility criteria for home health care, a recipient must have an illness, injury, or disability that prevents the individual from going to a physician's office, clinic, or other outpatient setting for required treatment and be unable to function without the aid of supportive devices, such as crutches, a cane, wheelchair or walker along with requiring special transportation or assistance from another person.

The client's attending physician must certify the need for home health and provide written documentation to the home health provider regarding the client's condition.

Section 3.3: Hospice Services

Hospice care is a comprehensive home care program that primarily provides medical and support services for terminally ill patients. Medicaid clients who voluntarily choose to end any treatment designed to cure their disease are eligible to receive services, supplies and care to provide necessary relief of pain or other symptoms. Clients currently receiving waiver services must terminate from the waiver program if they elect to receive hospice services through a Medicaid provider.

Section 3.4: Non-Emergency Travel (NET)

The Non-Emergency Transportation (NET) Program provides necessary non-ambulance transportation services to Medicaid recipients. Medicaid pays for rides to a doctor or clinic for medical care or treatment that is covered by Medicaid. In order to access this service, the recipient (or someone who is helping the recipient, i.e., CM, CG) will need to call Medicaid's toll-free number at 1-800-362-1504. The NET hotline is open from 8:00 a.m. to 4:00 p.m., Monday through Friday, except on state holidays. The waiver case managers are responsible for ensuring that all waiver clients are aware that this service is available.

Section 3.5: Durable Medical Equipment (DME)

Medicaid authorizes DME, supplies, appliances, and Pedorthics (POP) to Medicaid recipients of any age living at home. Participating providers are those Home Health Agencies, pharmacies, DME, supply, appliance and POP suppliers contracted with Medicaid for this program. A provider of these benefits must ensure the following:

- The DME, supplies, appliances, and POP are for medical therapeutic purposes.
- The items will minimize the necessity for hospitalization, nursing facility, or other institutional care.

The prescriber is responsible for ordering the items in connection with his or her plan of treatment. The prescriber must be a licensed, active, Alabama Medicaid provider. The provider is responsible for delivering and setting up the equipment as well as educating the recipient in the use of the DME.

Prior Authorization (PA) requests for coverage of DME must be received by Medicaid's Fiscal Agent within 30 days after the equipment is dispensed.

If a client demonstrates a need for DME, the CM should contact the DME provider of the client's choice in order to coordinate a resolution.

Section 3.6: Gateway to Community Living Demonstration (GCL)

The Gateway to Community Living is an Alabama Medicaid initiative that expands home and community-based resources for Alabamians who are aging or have disabilities. It is part of a rebalancing demonstration that is funded through the Centers for Medicare and Medicaid Services (CMS) Money Follows the Person (MFP) program. The GCL provides supports to individuals who wish to transition from nursing homes and institutional settings to a home and community based setting. The program utilizes the state's existing long-term care system as a foundation, allowing individuals currently living in institutional settings to enroll in one of seven Home and Community-based Waiver programs. The goal of the Demonstration is to support individuals to successfully transition from institutional settings to community living, while further enhancing the State's infrastructure so that community living is an option for all Alabamians regardless of disability.

Section 3.7: Medicaid Prior Authorization

AMA is responsible for identifying services that require prior approval. Prior authorization serves as a cost-monitoring, utilization review measure and quality assurance mechanism for the Alabama Medicaid program. Federal regulations permit AMA to require prior authorization (PA) for any service where it is anticipated or known that the service could either be abused by providers or recipients, or easily result in excessive, uncontrollable Medicaid costs.

Section 3.8: Home and Community Based Settings

Waiver services must be provided in settings that are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, 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.

Section 3.9: Freedom of Choice

CMS mandates (as provided in 42 CFR 441.302(d)) that waiver participants are informed of and able to exercise the right of freedom of choice of waiver services and providers, and to choose between home and community based services and institutionalization. Each waiver client must make a written choice (on the HCBS-1, aka Medical) for either institution or community care, which will remain in effect until such time as the client changes his/her choice. The only exception to making a written choice is when the client is not capable of signing the form. In such cases, services are not denied if a written choice cannot be obtained. The reason(s) for absence of a signed choice must be carefully documented by the case manager.

CMS also mandates that a client be free to choose DSP of his/her choice. Freedom of Choice regarding the provider agency should be offered to the client/caregiver at the time of initial assessment, each reassessment, whenever a change of service provider is requested and/or the current provider becomes unable to continue services. The client may request at any time for his/her case be transferred to

another service provider agency or for a different worker to be placed in the home. The client may also request a change of case manager.

The selection of DSPs is documented on a separate form (MW-14) and serves as documentation that the client has been afforded a choice. The form lists the client's preference by order of the first three choices. It must contain the client's signature and the date it is signed.

The DSP and the AAA have the right to refuse service provision to the client if they are unable to meet the client's needs or the client's health and safety cannot be maintained. Special needs of the client, such as weekend service or specific hours of the day or evening, should be reflected on the Service Authorization Form and documented in the narrative. These needs should be presented to the chosen provider, giving that provider the opportunity to accept or reject the referral.

Section 3.10: Estate Recovery

The Estate Recovery program was established under federal law and requires that AMA seek to recover costs paid by Medicaid on behalf of recipients for medical services. Recovery of money spent is made from the estate of certain deceased recipients who had qualified assets at the time of their death. Questions regarding letters received may be referred to 1-855-543-8395.

Part 4: Medicaid Waiver Programs Available through ADSS

Section 4.1: Medicaid Waiver Home and Community Based (HCBS) Programs Overview

Section 4.1.1: Overview

The Medicaid Waiver HCBS programs are designed to serve Medicaid-eligible individuals who meet nursing home medical level of care requirements and are at risk of nursing home placement. These programs provide the ability for health, safety, and dignity to be maintained while reducing the cost of Medicaid institutional care by serving individuals in the community.

Section 4.1.2: Intake Screening

Prior to assessment for the waiver program, the case management staff for the waiver programs screens the applicant for their desire for waiver participation and their likelihood to meet financial and level of care eligibility criteria. These activities are preliminary requirements for waiver enrollment and are distinct from case management activities. These activities are documented in the case record and are considered administrative activities.

The intake and screening process is involved and must include documentation regarding the following:

- The applicant has been informed about the application process;
- The applicant has been informed of all DSP and allowed his or her freedom of choice of providers;
- The applicant has been informed of all HCBS programs of which he or she may benefit and allowed freedom of choice of programs;
- The applicant has been informed of choice options regarding case management services;
- The applicant must indicate a written choice between institutional or community care. The only exception to a written choice is when the client is not capable of signing the form. In this situation, approval for waiver services should not be denied if a written choice cannot be obtained. The reason for the absence of a signed choice should be well documented in the case record. Signatures with the mark of an X or signatures by a legal representative are acceptable and should be made in accordance with the requirements outlined in Section 5.13.
- Documentation should also include:
    - The setting and the persons present and the involvement of the applicant and or significant other during the assessment process;
    - The support systems (formal and informal) that the applicant currently receives;
    - The service needs; Emergency backup plan for those applicants who are considered "at risk" if visits are not made. (A disaster preparedness plan should also be in place.);
    - The case manager documentation that he or she has discussed the client's rights and responsibilities with the client, responsible party, and/or significant other.

Section 4.1.3: Application Process

The Home and Community-Based Services Program Assessment (HCBS-1) is the required application developed by AMA for support of the assessment, risk of institutionalization, and POC.

- The case manager with the aid of the applicant's physician must complete the HCBS-1 application on all individuals that have been determined appropriate for admission to the program.

- The case manager is responsible for obtaining the most reliable and accurate information available. The applicant's diagnoses and medications should be indicated on the HCBS-1 application.

- The signature of the applicant should be present to ensure that the applicant has been involved in the care plan development and has given the OA permission to share information with involved providers.

- The physician's signature should be present to indicate that the applicant is at risk for institutional care and that HCBS will prevent or delay the need for institutional care.

- The POC must include the name of the provider of services, objectives, services, frequency of services, and the start and end dates for the services. Any changes to the POC must be documented.

- The HCBS-1 application must be submitted to the OA nurse consultant by the case manager upon completion by the physician. The OA nurse consultant will review the application to obtain a clear picture of the client's medical status and functional abilities, psychosocial behavioral status, and home environment.

- If the information is complete and supports the above and the criteria developed by AMA, the OA nurse consultant will approve the application. The application will be processed through the HP system. The application will have up-front edits performed. If there are no problems identified, the system will produce a LTC segment and an acceptance will be returned to the OA. The LTC segment validates approval for dates of service delivery. If the upfront edits performed identify problems, then a rejection notice will be returned to the OA with reasons for the rejection. Corrections must be made and the information resubmitted to the HP system.

- The case manager will be informed of the approval when received. The case manager will in turn provide a service authorization to the provider chosen by the recipient for the initiation of service delivery.

- If the information on the application is not complete, the OA nurse consultant will return the application to the case manager for additional information.

Section 4.2: State Definition of Nursing Home Level of Care

Medicaid Waiver Services are available to eligible clients in the community who meet the current institutional nursing facility admission criteria and who:

- Are at the point of discharge from a general acute care facility, and without the availability of waiver services would be eligible for placement in a nursing facility.
- Reside in the community, but are in danger of institutionalization, when their disabilities and level of functioning are such that, without the availability of waiver services nursing facility placement would probably occur.

- Are residents of a nursing facility, and who opt to leave that facility because of available HCBS.

Section 4.3: Costs for Services

The costs for individuals who qualify for waiver services may not exceed the total expenditures that would be incurred if waiver services were not available.

Section 4.4: Waiver Capacity (Slots)

Each Medicaid Waiver has the capacity to serve a specified number of clients statewide. Currently the E&D Waiver is allotted 9,205 slots statewide. The 530 Waiver has the capacity for 150 slots, ACT Waiver has 675 slots, and TA Waiver may increase to up to 80 slots.

CMS requires OAs to reserve slots for applicants currently in a skilled nursing facility. The purpose of reserving the slots is to assist Alabama Medicaid eligible recipients who desire to transition from nursing facilities back into the community. The reservation of these slots will allow those individuals who are able to transition to be placed in a preserved waiver slot during the current waiver year. These applicants would not be placed on a waitlist, but prioritized using the reserved slots. The E&D reserves 100 slots for this purpose, 530 reserves 5, and TA reserves 5 (ACT does not have a reserve since the target population for this waiver is Medicaid recipients in a skilled nursing facility).

Once a person has been approved to receive services, that slot is considered filled if the client receives any benefits for which the AAA, COG, RPC is reimbursed, regardless of the type, amount or duration of services. The slot may not be refilled, except by the same client, until the beginning of the next fiscal year. A person who is approved, terminated and re-approved in the same year is considered to fill only one slot. The 530 Waiver program is the exception and the slots may be refilled as necessary.

A case that terminates for any reason before any services are provided may be refilled. The termination form (AIMS-2) of such cases should indicate that no services were received in the "other" block of the AIMS-2 form.

When a recipient is denied services, the application of that recipient will be returned to the AAA/COG/RPC with a denial letter. This application and slot will be held until it is determined whether the client will request an appeal of the denial. If the client requests a hearing, the slot for that recipient must be retained by the AAA/COG/RPC until the matter is adjudicated. If no appeal is requested, the slot will be released back to the AAA to be used again.

Section 4.5 Caseload Management

The full time case manager should maintain a caseload of 35-40 clients depending upon factors such as the geographic area to be covered, additional responsibilities and/or individual waiver program requirements.

Section 4.6 Services

The cost of services provided through the waiver programs cannot exceed institutional facility costs. The waiver programs are not designed to offer 24-hour care or 40-hour per week care. Such provision would be too costly to warrant approval. In those cases in which the client needs supervision during absences of an employed caregiver, the case manager can arrange for a combination of waiver services, volunteer programs, adult day health, and services paid for by the caregiver. Emergency situations, such as increased disability of the client or decreased capability of the primary care giver may be justification

to allow a temporary increase in services. This period of time should be sufficient to either arrange additional non-waiver resources, allow time for the situation to return to its prior need level, or until nursing home placement occurs. These events should be clearly documented in the narrative of the case record.

Waiver services cannot be delivered to persons who meet any of the following:

- Reside in a domiciliary or assisted living facility;
- Reside in a nursing facility;
- Receive services through any other approved and implemented HCBS waiver program;
- Have a primary diagnosis of mental illness and/or mental retardation;
- Are not approved for the services indicated on the POC;
- Choose nursing facility care;
- Move to another state;
- Refuse to sign the HCBS-1 form;
- Whose health and safety is at risk in the community as determined by AMA and/or the OA;
- Are uncooperative with a provider in the provision of services;
- Have Medicaid eligibility blocked due to transfer of assets;
- Are in a hospital or other acute care facility;
- Are in a hospital PHEC bed or swing bed;
- Reside in a ICF/MR facility;
- Receive Hospice services paid for by Medicaid;
- Reside in a boarding home;
- Are unable to provide a healthy and safe environment in which waiver services can be delivered;
- Are unable to sustain an environment in which providers are treated with dignity and respect.

Section 4.7: Federal HCBS Waiver Assurances

The six assurances are:

- Level of Care: Participants enrolled in the HCBS waiver meet the level of care criteria consistent with those residing in institutions.
- Service Plan: A person's needs and preferences are assessed and reflected in a person-centered service plan.
- Qualified Providers: Agencies and workers providing services are qualified.
- Health and Welfare: Participants are protected from abuse, neglect and exploitation.
- Financial Accountability: A state Medicaid Agency pays only for services that are approved and provided, the cost of which does not exceed the cost of a nursing facility or institutional care on a per person or aggregate basis (as determined by the state).
- Administrative Authority: A state Medicaid Agency is fully accountable for HCBS waiver design, operations and performance.

Section 4.8: Elderly and Disabled Waiver (E&D) Section

The Elderly and Disabled Waiver program provides services to elderly and individuals with disabilities who meet the nursing facility level of care and who are at risk of institutional placement without the services of the E&D program. ADSS is the OA for the E&D Waiver.

Section 4.8.1 - E&D Waiver Financial Eligibility

- Individuals receiving SSI
- Disabled individuals with income up to 300% of the SSI income level

- Institutional Deeming

Section 4.8.2 - E&D Waiver Slots:

- 9,205

Section 4.8.3 - E&D Waiver Specific Program Requirements:

- No age requirement

Section 4.8.4 - E&D Waiver Services:

- Case Management
- Personal Care
- Homemaker Services
- Adult Companion Services
- Skilled/Unskilled Respite
- Meals

Section 4.9: HIV/AIDS Waiver (530)

The HIV/AIDS (530) Waiver program provides services to individuals diagnosed with HIV/AIDS or related illness who require nursing facility level of care and are at risk of institutional placement without the services available through the 530 Waiver.

Section 4.9.1 - 530 Waiver Financial Eligibility

- Individuals receiving SSI
- Disabled individuals with income up to 300% of the SSI income level
- Institutional Deeming

Section 4.9.2 - 530 Waiver Slots

- 150

Section 4.9.3 - 530 Waiver Specific Program Requirements

- Persons age 21 and above

Section 4.9.4 - 530 Waiver Services

- Case Management
- Personal Care
- Homemaker Services
- Skilled Nursing
- Adult Companion Services
- Skilled/Unskilled Respite

Section 4.10: Alabama Community Transition Waiver (ACT)

The ACT Waiver program provides services to individuals with disabilities or long-term illnesses who currently reside in an institution and who desire to transition to a home or community based setting. The program is also an option for individuals currently being served by one of Alabama's other HCBS waiver program whose condition is such that their current waiver is not meeting their needs and

admission to an institution would be imminent without services through the ACT Waiver. ADSS is the OA for the Alabama Community Transition (ACT) Waiver.

Section 4.10.1 - ACT Waiver Financial Eligibility

- Individuals receiving SSI
- Disabled individuals with income up to 300% of the SSI income level

Section 4.10.2 - ACT Waiver Slots

- 200

Section 4.10.3 - ACT Waiver Specific Program Requirements

- No Age Requirement
- Individuals determined to be eligible for transition into the community based upon an assessment
- Individuals that are expected to move into the community within 180 days

Section 4.10.4 - ACT Waiver Services

- Case Management
- Transitional Assistance Services
- Personal Care
- Homemaker Services
- Adult Day Health
- Home Delivered Meals
- Skilled/Unskilled Respite
- Skilled Nursing
- Adult Companion Services
- Home Modifications
- Assistive Technology
- Personal Emergency Response Systems (PERS) –Installation/Monthly Fee
- Medical Equipment Supplies and Appliances
- Personal Assistant Service (PAS)

Section 4.11: Technology Assisted Waiver (TA)

The Technology Assisted Waiver (TA) program provides services to adults with complex skilled medical conditions who are ventilator dependent or have a tracheostomy. These individuals require nursing facility level of care and are at risk of institutional placement without the services available through the TA Waiver.

Section 4.11.1 - TA Waiver Financial Eligibility

- Individuals receiving SSI
- Disabled individuals with income up to 300% of the SSI income level
- SSI related protected groups deemed to be eligible for SSI / Medicaid

Section 4.11.2 - TA Waiver Slots:

- 40

Section 4.11.3 - TA Waiver Specific Program Requirements

- Persons 21 years of age and older

Section 4.11.4 - TA Waiver Services

- Targeted Case Management
- Private Duty Nursing
- Personal Care/Attendant Services
- Medical Supplies: Supplies are limited to $1800 per client, per waiver year unless medically necessary and approved by Medicaid.
- Assistive Technology: This service is limited to $20,000 unless medically necessary and approved by Medicaid.

Section 4.12: Personal Choices

The basis for *Personal Choices*, Alabama's Cash and Counseling program, is to allow eligible individuals the ability and flexibility to select and design a method of long term care services and supports that meets individual needs. Specifically, it allows for individuals to self-direct specific services such as personal care or personal attendant services.

The Personal Choices Program is offered throughout the State's HCBS waivers. The program targets existing Medicaid waiver recipients from the Elderly and Disabled (E&D), The Alabama Community Transition (ACT), HIV/AIDS, and the Transitional Assistance (TA) Waivers, administered through ADSS. *Personal Choices* serves seniors, adults with physical disabilities and children currently receiving personal care or personal assistance in the E&D, HIV/AIDS, ACT, or the TA waivers.

Under the Personal Choices program, individuals are provided a monthly allowance from which they determine what services they need. They may choose to hire someone to help with their care or they may wish to save money for equipment purchases. A Counselor is available to guide them through the process which includes developing a budget to help manage the funds designated for their care. A Fiscal Intermediary Agency performs background checks for potential employees, disburses budget funds and processes payroll in addition to ensuring IRS requirements are met for the participants in the program.

Part 5: Application and Start of Waiver Services

Section 5.1: Request for Application

Individuals who are in need of in-home services may contact ADSS for assistance through the Aging and Disability Resource Center (ADRC) located in the 13 AAA Regions. Case managers will contact the individual once a referral is made and begin the application process.

Section 5.2: Medicaid Eligibility: How to apply for Medicaid

Individuals wishing to receive in-home services through the waiver program that are not currently Medicaid eligible will need to make application with Medicaid. Each Medicaid program has its own age requirements and certain income requirements that must be met in order to qualify for benefits. Individuals may apply in person at one of the Medicaid District Offices or may call toll-free 1-800-362-1504 for additional help.

Section 5.3: Institutional Deeming Process

Individuals who meet the medical level of care and are "at risk" for intuitional placement, may qualify for services of the waiver program through the institutional deeming eligibility category. In order to become financially eligible for Medicaid, the process outlined below must be followed.

Section 5.3.1 - Initial Steps (AAA Case Manager)

- When a referral is taken on a deeming client, the case manager will contact the client to explain the deeming process paperwork. If the client wants to pursue the application process, the case manager will schedule an appointment for the assessment to be completed and either mail the client the 204/205 application to the client or provide it at the assessment visit.
- The client is to complete the deeming application (HCBS/204/205). The case manager is to inform clients they have **20 days** to submit the necessary information/paperwork. If an extension is needed, allow no more than 10 days.
- The case manager is to collect **ALL** documents needed to submit a complete application to the District Office. If the client has not submitted **ALL** pertinent documents to the case manager, the case manager will contact the client to provide notification that the case will be closed.
- Once the assessment has been performed, the case manager is to forward the medical form to the appropriate physician for completion.
- Once **ALL** documents are received for the packet, the case manager is to complete and submit the HCBS application in AIMS. The application should be marked as "deeming" on the nutritional tab and documented as "deeming or 300% case" in the comments section.
- Once a SLOT confirmation is received, applications must be submitted to the Medicaid District Office as soon as possible. **The case manager is to complete the information related to the submission to the district office and send a copy to the ADSS nurse.**
- The case manager is responsible for checking Eligibility on these clients every month while awaiting an AWARD or DENIAL from the DO. If the client status is noted as "Eligible" or "Denied", the case manager will need to contact their DO and have them email a copy of the letter to ADSS. Failure to perform this activity could result in a delay of services, as many times notification letters are not forwarded to ADSS. This process will identify missed AWARD/DENIALS that are never sent to ADSS.
- IF for any reason the client is discharged before finishing the process, whether they withdraw their application, progress notes are never received, or the client relocates, the CM needs to inform ADSS they are discharging the client so that the case can be closed at ADSS.

Section 5.3.2 - Approval of Medical Level of Care (ADSS)

- The ADSS Nurse will review the application for the medical level of care approval. If needed, additional information will be requested.
- If approved, the ADSS Nurse will complete and e-mail the waiver slot confirmation form (FORM 376) to the case manager.

Section 5.3.3 - Completing Packet/Mailing to the District Office (AAA)

The case manager will complete the date sent to the district office field on the FORM 376 and initial to indicate the information was sent on date listed. A copy of the form is to be sent to ADSS.

Section 5.3.4 - Approval/Award of Medicaid Eligibility (Medicaid District Office)

- The district office will fax the Award letter/ denial letter to ADSS.
- Once approved by the district office, ADSS will submit the application through the HP system.
- The approval date is the date the application was originally approved by the ADSS nurse.
- When the HP approval report is received, the application will be approved in AIMS.
- The ADSS nurse will email or fax the award letter to the case manager.

Section 5.3.5 - Denials (ADSS)

- The ADSS nurse will reject the application through AIMS noting the denial in the AIMS "mail box" where comments are noted for the case manager.
- The denial letter will be mailed to the case manager.

Section 5.3.6 - Miscellaneous Information

If the District Office Worker needs progress notes for a disability determination, the case manager will receive a notice and a checklist of what is needed. Do NOT request progress notes on the disability determinations unless a request is received for them. Notes may be scanned then e-mailed to the worker.

Case managers must notify the district office immediately if a deeming client is terminated from the waiver program for any reason.

When a deeming client is reinstated after a nursing home stay, the case manager must verify with the district office the date of waiver financial eligibility.

If a current waiver client is losing financial eligibility, notify an ADSS nurse for a slot confirmation form (Form 376), and put services on hold. Do not discharge from the waiver. It is not necessary for the case manager to obtain a new medical or submit a new deeming application to ADSS unless redetermination lapses at same time the financial is lost. The ADSS nurse will fax the Slot only form (Form 376) to the case manager. The case manager will attach Form 376 to the 204/205 and submit directly to the Medicaid DO. ***IF TIME PERIOD OF FINANCIAL INELIGIBILITY EXCEEDS 100 DAYS** the application must be processed as a readmission with a new medical form, and HCBS application.

Section 5.4: Level of Care Criteria

Medical eligibility for the waiver programs is based on the current Medicaid admission criteria for nursing home placement. The qualifications for meeting the criteria is outlined below. **The application must meet at least two of the A-K criteria for initial admissions, re-admissions and re-determinations. Supporting documentation must be provided for all criterions checked. A copy of the medical form is**

provided in Appendix B.

Section 5.4.1 - Block "A".
Administration of a potent and dangerous injectable medication and solutions on a daily basis or administration of routine oral medications, eye drops or ointment. ***(Cannot be counted as a second criterion if used with criterion K-7)***. The medications must be listed in the "Medication Prescribed" section of this form.

All medications listed need to have a supporting diagnosis to go with it. Medications taken over the counter such as "Aspirin", can apply to this criteria, if the doctor has prescribed them to be taken every day. **ALL "attached" medication lists MUST have the clients Name, Medicaid Number and the Date printed on the attachment.**

Daily is 7 times per week. Routine is less than daily but on a regular and continuing schedule. (Example: B12 injections monthly)

As needed (PRN) will not support this criterion.

G Tube administration will support this criterion.

Medications are entered into AIMS by the case manager. There are many helpful Internet sites that can be used to find medication names. **Do not guess!** If you cannot read the medication name, call the physician's office for the correct spelling or call the nurse at ADSS doing the level of care determination for assistance. The medications are used by the reviewing nurse to make the medical determination.

Section 5.4.2 - Block "B".
Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of clients who are determined to have restorative potential and can benefit from the training on a daily basis per the physician's orders. Examples include: speech, physical and respiratory therapy on a daily basis. Supporting information is required on the care plan under non-waiver services, such as, who is providing therapy, how often and the date of the last assessment.

The patient needs to be receiving therapy at least 3 times per week in the community setting to support this criterion.

Therapy by a family member must be supported by who is following the therapy and it must be monitored by a professional. (HH, MD etc.)

This criterion requires a diagnosis to support need. (Example: CVA...PT to improve gait)

Range of Motion (ROM) will not support this criterion.

Remember: restorative nursing cannot continue for months or years without being reassessed.

Section 5.4.3 - Block "C".
Nasopharyngeal aspiration required for the maintenance of a clear airway. This is used for anyone

that is getting suctioned to keep their airway clear. The patient will need a medical diagnosis to support the need for suctioning. (Example: Closed head trauma.)

Frequency and who provides the suction should be listed under the non-waiver services section on the care plan.

Section 5.4.4 - Block "D.

Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created. ***(Cannot be counted as a second criterion if used in conjunction with criterion K-3 if the ONLY stoma (opening) is a G or PEG tube. Cannot be counted as a second criterion if used in conjunction with criterion K-4 if used for colostomy and ileostomy.)***

This criterion is checked for anyone with a "G-Tube" for feeding or any other tube that may be in place in the clients' body except an urination tube with a bag (Foley catheter) that a nurse comes to check and change frequently. A Foley catheter will not support this criterion.

The comment section or additional diagnosis (medical form) should indicate the type of tube the patient is using.

Non-waivered services on the care plan should indicate who provides care and what care is provided. (Example: G Tube/Peg Tube, medication administration and flushed TID)

Section 5.4.5 - Block "E".

Administration of tube feedings by naso-gastric tube. This is VERY RARE. It is a tube in the nose; most people do not have this at home.

Section 5.4.6 - Block "F".

Care of extensive decubitus ulcers or other widespread skin disorders. Please put in the comments section what type of skin disorder the client has. If it is a Decubitus ulcer (bedsore), on the care plan under non-waivered services, indicate the stage of wound, where the wound is, who is providing wound care and how often someone is taking care of it.

Section 5.4.7 - Block "G".

Observation of unstable medical conditions required on a regular and continuing basis that only can be provided by or under the direction of a registered nurse. (*Cannot be counted as a second criterion if used in conjunction with criterion K-9).* This can also be provided by the clients' physician. State what the unstable medical conditions are (if they are not obvious), who provides the observation and how often (regular and continuing basis is defined as no less than every 3 months) (Foley catheter).

Section 5.4.8 - Block "H".

Use of oxygen on a regular or continuing basis. Please put in the comments section when the client is using the Oxygen. The client must be using the Oxygen REGULARLY **or** CONTINUALLY. Regular can be at night only or day only; however, PRN is not regular and continuing.

Section 5.4.9 - Block "I".

Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, postoperative, or chronic conditions per physician's orders. Indicate who is doing the dressing changes and how often.

Section 5.4.10 - Block "J".

Comatose client receiving routine medical treatment. If the client is non-responsive at all times to people, place or surroundings, this is the correct criteria.

Section 5.4.11

- Block "K".

Assistance with at least one of the activities of daily living below on an ongoing basis: ***(Check all boxes below that apply. See additional information concerning criterion K below.)***

(Criterion K should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance. Multiple items being met under (K) will still count as one criterion.)

1. **Transfer- The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis** ***(daily or two or more times per week).***

2. **Mobility- The individual requires physical assistance from another person for mobility on an ongoing basis** ***(daily or two or more times per week).*** **Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane or other mobility aid shall not by itself be considered to meet this requirement.**

3. **Eating – The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.** ***(Cannot be counted as a second criterion if used in conjunction with criterion D if the ONLY stoma (opening) is a G or PEG tube.)***

4. **Toileting – The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care or indwelling catheter care on an ongoing basis** ***(daily or two or more times per week). (Cannot be counted as a second criterion if used in conjunction with criterion D if used for colostomy and ileostomy.)***

5. **Expressive and Receptive Communication – The individual is incapable of reliably communicating basic needs and wants** ***(e.g., need for assistance with toileting; presence of pain)*** **using verbal or written language: or the individual is incapable of understanding and following very simple instructions and commands** ***(e.g., how to perform of complete basic activities of daily living such as dressing or bathing)*** **without continual staff intervention.**

6. **Orientation – The individual is disoriented to person** ***(e.g., fails to remember own name or recognize immediate family members)*** **or is disoriented to place** ***(e.g., does not know***

residence is a Nursing Facility).

7. **Medication Administration – The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes but not limited to, reminding when to take medications, encouragement to take reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose. (*Cannot be counted as a second criterion if used in conjunction with criterion A).***

8. **Behavior – The individual requires persistent staff intervention due to an established and persistent pattern of dementia- related behavioral problems *(e.g., aggressive physical behavior, disrobing or repetitive elopement attempts)*.**

9. **Skilled Nursing or Rehabilitative Services – the individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration or intensity than for practical purposes would be provided through a daily home health visit. (*Cannot be counted as a second criterion if used in conjunction with criterion G).***

Section 5.5: Waiver Assessment

The case manager will schedule an in-home visit with individuals requesting services through one of the available waiver programs. At the initial home visit, the case manager will gather necessary information and assist in developing a POC for the individual based upon desired goals and outcomes. The individual is encouraged to have family members and other support persons present at the time of the initial assessment.

Section 5.5.1 HCBS ASSESSMENT FORM

Each page **must** be completed and transmitted via AIMS as a part of the application process. A copy of the completed form will be kept in the case file, and another given to the DSP at both the initial client assessment and at each annual redetermination.

The "Initial Assessment "is for individuals not currently enrolled in a waiver program. **Do not** place a date in the "Date Eligibility Expires" field as this is for redeterminations.

Accurate completion of the ADL section is important as this information will be used in formulating a POC and providing support documentation for the medical level of care. List the names of anyone providing the assistance and include a telephone number for that person.

The comment section should be utilized for documentation of additional information that supports the clients need for waiver services. **Do not** repeat information listed elsewhere on the application (i.e. medical diagnosis).

Section 5.5.2 MEDICAL FORM

The **original** copy of the medical form must be kept in the client record. A copy must be given to the DSP at both the initial client assessment and each redetermination.

This form requires an **original** signature by the physician or his/her designee and three signatures by the client. Rubber stamps, white out, stickers, or a signature by any other person other than the client's physician or his/her designee is **not acceptable.**

The **original** form will be reviewed during on-site audits. Forms not completed correctly may result in recoupment of funds if found not in compliance with Federal Regulations. Changes to the original form cannot be made without the approval of the physician or his/her designee. Any changes to the form must reflect the following:

- Date of contact
- Name/position of the person contacted
- Change made to the document.

All Initial Applications, Readmissions, Redeterminations and Reinstatements **must** have two (2) or more criteria checked for admission to the waiver program.

Section 5.5.3 Program Forms

Please see Appendix B for other required program forms.

Section 5.6: Care Plan

The Care Plan is a statement of goals to meet client's needs and identification of services necessary to achieve those goals. The care plan development is a person-centered process. The client/identified caregiver will be heavily involved in the care planning process as they will be setting the desired goals and outcomes for the services they receive. These decisions include type, frequency and duration of services. The services provided in the waiver program are not designed to replace, but to supplement his/her current support systems.

Care planning is the link between the assessment, identification of needs/desired outcomes and the delivery of services; it is the action taken to address identified problems. Care plans must be updated when a permanent change is made in the service.

Section 5.6.1 Case Manager's Role

Case managers are expected to:

- Develop a clear and factual care plan for each client based on individual needs/desired outcomes that addresses all service requirements.
- Explore all service alternatives with the client before finalizing the plan.
- Maintain a listing of service agencies, organizations, the services provided by each, and eligibility requirements for those services and the contact person to aid in the care planning process.
- Assist in the development of specific goals for the client.
- Use beginning and ending dates appropriately on the care plan.

Section 5.6.2 Care Plan Requirements

1. The care plan must be completed fully, signed by the client, and the original must be kept in the case file, a copy placed in the in-home file and another copy given to the DSP at both the initial client assessment and all redeterminations. Any permanent changes to the care plan will require new signatures by the client.

2. All waiver and non-waiver services must be listed on Care Plan. A care plan should reflect ALL assistance and services received by the client. This includes services provided under the waiver programs and other non-waiver services such as hospice, home health, personal care under Medicaid, informal support by family, friends, civic or church groups, as well as doctor visits and all non-paid services by agencies or organizations,

3. Under the frequency column, indicate the amount and number of times the service is provided. Example: "2xwk 3hrs". Do not use the names of the days of the week as they may change. For the frozen meals services use "1xwk, 1 or 2 unit(s) wk"

4. Services listed on the Care Plan must be based upon the diagnoses stated on the Medical Form. ADSS/AMA/CMS will not approve services that do not appear to be needed to maintain the client in the community.

5. Respite care must be labeled as unskilled or skilled as they are two separate services, yearly limitations apply for some waiver programs.

6. The items on a care plan must match those billed. For example, if personal care has not been approved as part of the care plan, the service is not eligible for Medicaid reimbursement.

7. In some instances, a family member has been trained to provide skilled services and the presence of a nurse is not necessary for certain clients. An explanation of this should be included on the assessment form and care plan.

8. Medicaid will not pay a physician to complete of the ADSS ASSESSMENT FORM. If the physician requires payment and bills the AAA/COG/RPC, this cost may be reimbursed as a case management expense.

Note: NEVER DELETE AN ENTRY IN AIMS. Enter an end date for the entry and create a new entry for other services needed in order to maintain a complete record of the care plan history.

Section 5.7: Initial Assessment Application

This application is used for new clients or those who have not been on the waiver for at least a year.

Guidelines:

- Requires all HCBS forms
- Care Plan services should be marked "upon approval"
- Services tab/ ADL tab services should be marked "needs"
- Medical form requires at least 2 admission criteria (K's only count as 1)
- Medical form requires signature dates <90 days
- Comments should indicate why client is "at risk" of nursing home placement
- Reason the client is unable to manage ADL's without assistance in comments.
- Support or lack of support available in home in comments.
- Services begin date is date stamped on top right of medical form in AIMS
- Service end date is last day of month of approval month following year
- Service begin date must be verified on MSIQ1 before start of service
- Financial eligibility is to be verified on MSIQ1 initially, at approval, and monthly.

Section 5.8: Readmission Application

This application is for clients who were on the waiver in the past year but were terminated, were off the program more than 100 days or missed their redetermination date. This also applies to redetermination

that are submitted past deadline, clients in a nursing facility greater than 100 days, and clients who were in a nursing facility on the last day of the redetermination month.

Guidelines:

- Requires updated HCBS forms
- Services tab/ ADL tab should be marked services "needs"
- The Medical form requires at least 2 admission criteria (K's only count as 1)
- The Medical form requires new signature dates <90 days
- The Comment section requires specific details of the course of events that has occurred during break in waiver services including specific dates
- Services begin date is date stamped on top right of medical form in AIMS
- Service end date is last day of month of approval following year
- Services begin date must be verified on MSIQ1 before start of services
- Financial eligibility verified on MSIQ1 initially, at approval, monthly
- A client has to be readmitted regardless of whether or not AIMS shows an open slot. If you need a slot to readmit a client, call ADSS.

Section 5.9: Reinstatement Application

This application is for clients who were previously on the waiver during the current year and were terminated (using AIMS 2) to enter a nursing home, were discharged back home and desire waiver services to be resumed. **EXCEPTIONS: If a waiver client has been in a Nursing Facility greater than 100 days and/or the client is in the Nursing Facility on the last day of the redetermination month, a Readmission Application would be required and the guidelines for readmission would be applied.**

Guidelines:

- Services are resumed after an in home face to face visit. HCBS application is updated with CM, client/CG, DSP supervisor and DSP worker if possible.
- Visit must occur within 10 days of notification of discharge
- Does not require new medical form
- Care Plan requires new start date for all services including case management (date the services are resumed)
- Care Plan services should be marked "uses"
- Service tab should be marked services "uses"
- ADL tab should include current DSP
- Medical form requires at least 2 admission criteria (K's only count as 1)
- Comment section requires date entered nursing home, date discharged; date services resumed and end date of re-determination
- Service begin date is date services are reinstated. Services can resume prior to ADSS approval. NH must enter their dates into MSIQ for ADSS/EDS reinstatement approval
- Service end date is date current re-determination expires
- Service date must be verified on MSIQ1
- Financial eligibility verified on MSIQ1 upon NH discharge, at approval, monthly

Section 5.10: Approval Notification

Upon approval, the ADSS nurse will input the approved dates to the Medicaid Long Term Care File and the case manager will be notified when the file is updated with the new effective date. The case

manager is to print a copy of the **AIMS-2 Form** and place in the client's case file. This is verification that waiver services have been approved.

Section 5.11: Denials by ADSS

An application may be denied under the following circumstances:

- There is no physician certification;
- A new admission application with less than two (2) medical criteria checked on the application;
- A request for additional medical information to process the application is not received within 60 days;
- The OA cannot safely maintain the individual in the community;
- The waiver does not cover the eligibility group.

If a denial is made by ADSS, ADSS will issue a denial letter to the client and copy the AAA. The denial letter will contain instructions on the appeal process. A copy of the letter is to be kept in the client's case file.

Section 5.12: Service Provider Authorization

Section 5.12.1 - Service Provide Authorization Form

Upon approval of a client for waiver services, the case manager will issue a written Service Provider Authorization Form (MW-13) to the DSP to initiate waiver services. The authorization of waiver services is based on the approved POC. A Service Provider Authorization (SPA) Form should be:

- Reviewed with the client/caregiver;
- Specific and accurate including the number of hours per visit and the number of days per week that the services are to be provided;
- Specify if the client is high risk by marking the appropriate block on the SPA form;
- Updated when there is a change in services and at each re-determination period;
- Signed/initialed and dated and;
- An original kept in the client's case file with a copy placed in the home of the client to be used by the client/caregiver, the DSP, Medicaid Quality Assurance (QA) Staff and ADSS QA staff.

Prior to initiating a service authorization, the case manager must contact the provider to determine the start date and discuss any special needs of the client. Identification is required of the client whose needs are such that the absence of an authorized waiver service would have a substantial impact on the client's health and safety. In cases where the client is determined to be "at risk" for missed visits, the authorization will be flagged when initiated. If the "at-risk" status changes, the existing authorization is revised and sent to the provider indicating the current status.

A client is determined to be "at risk" if their special needs and/or support situations are such that the absence of an authorized waiver service would have a substantial impact on the client's health and safety and there are no other reliable support systems.

The emergency/disaster priority status is entered on the Service Authorization Form according to the description below and service planning is required in an attempt to meet the needs of a client who would be vulnerable during the emergency/disaster:

- **Not Priority** - Client is not vulnerable during emergency/disaster or has adequate supports to meet his or her needs. (Example: Client with functional deficits, but family willing and able to evacuate and/or meet needs.)
- **Priority, Client Lives Alone** - Client lives alone and is vulnerable in emergency/disaster due to limitation of support system. (Example: Client lives alone and has no one available to evacuate him or her or has no one to give insulin.)
- **Priority, Advanced Medical Need** - Client has advanced medical needs and would be vulnerable during an emergency/disaster. (Example: Client is on ventilator, dialysis, or other specialized equipment/service.)

Section 5.12.2 - Case Manager Requirements

The case manager should have services in place within three days. Services not initiated within three days will require a written justification via the narratives.

The services listed on these forms must mirror those listed on the Care Plan and in the narrative.

The case manager must be sure each client has a copy of the applicable form(s) placed in the client's home. The in-home copy(s) must not contain the client's social security number, Medicaid number, prescription information or diagnoses. Should the worker need to know that information, it is available at the DSP's office.

In the event the in-home forms are lost or misplaced, it is the responsibility of the case manager to replace them. They must be in place for auditing purposes. Each client is to have their own individual file. Spouses are not to share a common file.

The case manager is to ensure that the forms are complete, current, signed/initialed and dated as required.

These forms are to be reviewed with the client/caregiver at **each** initial assessment, redetermination, Care Plan change and as otherwise needed.

The case manager is to conduct a meeting (introductory visit) with the DSP worker, his/her supervisor and the client/caregiver at initial assessment, when there is a change in worker and on an as needed basis. If the client changes to a new DSP but retains the same worker, an introductory visit is not necessary.

The case manager will discuss the assigned tasks with the client/caregiver and the worker and document as required in the narrative.

Section 5.13: Signatures

Section 5.13.1 - Client Signature On Forms for Waiver Services

If the client is able, the client should always sign his/her name on all required documents/forms for waiver services. If the client is not able to sign his/her name, he/she may mark the form with an "**X**" or other mark. **The case manager must document why the client did not sign for themselves.** Please note that the mark or "X" must be **witnessed**. The case manager can be a witness to a marked signature. The person witnessing the mark must

sign as indicated in the example below.

Example for client signing with an "X" or mark:

SIGNATURE: X (client mark) Witnessed By: _____John Smith_____

If the client cannot make an "**X**" or mark, the **primary caregiver or a family membe**r may sign for the client. Initials are not considered signatures and if used should be witnessed in the same manner as the "X" or mark. *The forms should never be signed by a case manager or service provider/worker under any circumstances.* The case manager must document why the client did not sign for themselves. **The person signing for the client should always indicate that by using the example below:**

Example for primary caregiver or family member signing for client:

Signature: Sarah Smith (Client) by John Smith (caregiver or family member).

Section 5.13.2 Signatures on the Case Management Forms

The *Case Management Home Visit* tool (MW-1) is to be used to record proof of the case manager visit. Under no circumstances may the clients signature be cut out and taped/pasted to the verification form.

The following applies for signatures on forms:

- The form must contain original signatures of the client/caregiver.
- The case manager must not sign for the client/caregiver under any circumstances.
- The service provider/worker must not sign for the client/caregiver under any circumstances.
- A minor cannot sign for the client or themselves. (In Alabama, you are considered a minor if you're under 19 and single. If you're 18 and married or a widow/widower you are no longer considered to be a minor)
- The case manager or worker can witness the client's mark or "X". Document why the client did not sign for themselves.
- The client/caregiver signature and date must be in the same ink, indicating they were signed at the same time. Blue ink is preferred.
- Signature stamps may not be used by the client, caregiver, case manager or DSP (to include workers and supervisors).
- The form may be signed by an authorized person that is designated by the client and or primary caregiver. Other designee(s) are to be listed on page 1 of the assessment and documented in the narrative.
- White-out is not allowed. A single line should be drawn through the item and noted as an error. The correction is to be added above the errored out item.

Section 5.13.3 Signature Card

In order for a digital signature to be utilized, the "MW-27 Signature Card" form must be signed and kept in the client's file.

If the client is unable sign, they must have a caregiver, with documented Power of Attorney, sign for them. If this requirement is not met, a client **must** sign the required paper forms. Parents signing for a child are exempt from this rule.

All services provided during a month that do not contain proper signatures on the verification form are recoupable by ADSS/AMA/CMS.

Part 6: Monitoring and Continuation of Waiver Services

Section 6.1: Level of Care Re-Determination

This application is for current clients and is done annually. Before each eligibility period of one year expires, a redetermination assessment is completed to determine the clients' eligibility and need for continued waiver services. Eligible clients are offered the alternative of HCBS or institutional services. A reassessment can be completed anytime new information warrants it. Redetermination applications have the same requirements as new applications. Due to the amount of data required for redeterminations, and frequent delays in receiving data, particularly from physicians, it is strongly recommended that case managers begin this process at least two (2) months prior to eligibility expiration. Medicals signed by physicians are accepted up to ninety (90) days prior to eligibility expiration. To prevent caseloads from becoming unmanageable, it is recommended to stagger the scheduling. Redetermination applications may be submitted up to 45 days in advance of the end of the current authorized dates.

Please note: Changing a redetermination date necessitates prior approval by ADSS. This will be reviewed on a case by case basis as changing the date necessitates a manual change by AMA. Requests for change will be approved only for extenuating circumstances.

Guidelines:

- Requires updated HCBS forms/New Medical
- Care plan dates do not change
- Service tab should be marked with frequency
- ADL tab includes current DSP name
- Medical form requires at least 2 admission criteria (K's only count as 1)
- Medical form requires signature dates <90 days
- Application must be submitted in AIMS to ADSS no later than the 15th day of the month in which eligibility will expire
- Applications can be submitted 45 days before eligibility expires.
- Comment section requires updating yearly
- Service begin date is last day of re-determination month current year
- Service end date is last day of re-determination month following year
- Services dates must be verified on MSIQ1
- Financial eligibility verified on MSIQ1 monthly

Section 6.2: Medicaid Eligibility

Medicaid eligibility is determined on a monthly basis. Each case manager is responsible for verifying that the client remains eligible each month and must document that eligibility has been verified in the client case file.

Section 6.3: Monitoring/Maintenance of Cases

Section 6.3.1: Monitoring

Monitoring is a process through which the case manager maintains ongoing contact with the client, his/her family, and the providers of service in order to ensure that the services are appropriate and meeting the client's needs. The case manager should monitor that services are appropriate, effective, provided in a timely manner and in accordance with CMS guidelines. The client/caregiver

should be instructed to notify the case manager, if services are not initiated as planned, or if the client's condition changes. Changes in the client's condition may require more frequent monitoring.

Section 6.3.2: Face to Face Visits

Case managers are expected to perform at least one (1) monthly face-to-face visit with the client. The visits should begin early in the month allowing enough time to finish all visits before the last week of the month. In the event the case manager is unable to complete the visit initially, the case manager must continue to attempt to complete the visit prior to the end of the month. Documentation in the narrative must reflect the attempts to visit the client. If a visit cannot be performed due to an unavoidable situation (disaster, significant weather event, hospitalization of the client in another part of the state), an exception to the requirement must be approved by ADSS. **Any and all services provided during a month without a face-to-face (unless approved by ADSS) is recoupable.**

The MW-1 form is to be used to document the visit. During the face-to-face visit, the case manager is to assess the clients' condition and perform a walk-through of the home to determine if the services authorized are being performed. The case manager should assess whether the services continue to meet the client's needs and whether the health and safety is being maintained. Information obtained during the visit should be documented either on the MW-1 form or in the case file narrative. All problems identified must have follow-up documentation.

If you have a difficult client or caregiver, it is extremely important to be thorough with documentation. Things you may not feel are important at the time, can be very important in a fair hearing or if the client is terminated because of non-compliance. If providers are having difficulty staffing a client because of non-compliance, it is important that they provide proper documentation, especially if they refuse to staff a client.

6.3.3: Case Record

The case record is the documentation that supports that the waiver requirements are being met. It verifies that the client meets medical and financial eligibility, is receiving the appropriate care and that client needs are being met. In addition, it supports that all services billed to Medicaid are eligible for reimbursement.

The Case Record Should Be:

- Organized with all current information together that is sorted chronologically.
- Maintained in the same manner from file to file beginning with the referral.
- Typed and checked for correct spelling and grammar.

Case records are to be maintained for at least five (5) years following the termination of services.

6.3.4: Case Narrative/Summary

AAA client files contain narratives that describe the plans, activities, actions and results related to their services. They are a planning tool, and a source of documentation and information that can be used by case managers, supervisors and QA monitors. AAA files can be chosen for review by a number of entities such as ADSS, AMA, CMS and others; therefore, accuracy and completeness in narratives are very important.

Narratives describe the actions taken and the reasons behind those actions along with the expected results. Consider narratives as the means to tell a factual story of the client (no opinions or comments of the case manager should be included). Anyone should be able to pick up the client file and follow the story of what is happening with the client.

Narratives should:

1. **Include the date of entry and the initial** of the case manager or other staff person.
2. **Be written in a timely manner**; write narratives while the information is fresh in your mind.
3. **Document activities** such as eligibility determination, registration and the development of service plans. Narratives should give a history of the client's situation, needs, and services planned and/or received.
4. They should **describe** how the client will benefit from HCBS Waiver services.
5. **Follow some sequence**. An issue mentioned in one case note should be followed-up with other narratives. It should be clear if a problem was resolved, if the client received a service, if the problem has worsened, etc. If a problem remains, the narratives should identify a plan of action/resolution.
6. **Be concise** and highlight major events, crises, barriers, etc. Anything that is pertinent to the client continuing the program (e.g. job search or training) or continuing to receive services should be listed.
7. For Supportive Services, **document needs**, resources explored, and actions taken.
8. **Document the rationale** for any change in the client's care plan (e.g. client has moved, client had a fall, client's symptoms have increased or decreased), how the decision was made (e.g. met with client and caregiver, if necessary, to develop new POC), and what the new care plan is.
9. **Be kept in the case file** - if narratives are maintained in a database, print them regularly and keep an updated copy in the client's file. Case files should be maintained in a locked file cabinet.

Write Narratives that are:

- Clear and brief
- Concise, precise
- Accurate and complete
- Timely: Write narratives while the information is fresh in your mind.
- Readable – acceptable grammar: **Review all work prior to submitting to ADSS.**
- *The application will be rejected if the intention is not understood.*
- Supportive: Write narratives which justify the need for services or changes in services.

The case narrative shall, with the inclusion of the *Case Management Home Visit* tool (MW-1), **stand alone**. Other items such as *Supervisory or Missed Visit* reports are to be placed in their own sections within the case file.

The case narrative is a written history of contacts with clients/caregivers and other significant people. The history is used to determine a client's initial and continuing eligibility. It is also the primary documentation of case management time for auditing purposes. To remain in compliance with policies and procedures set forth by AMA, a face-to-face contact visit must occur each month and as needed with the client. Entries in the case narrative serve to corroborate the signed verification and case manager's time spent on a case. It is mandatory that the dates on both accounts agree.

6.3.5: Case Narrative/Redetermination Summary

Redeterminations must be performed on an annual basis. The summary of the redetermination review is to be documented on the HCBS-1 form. A separate narrative does not have to be included in the running narrative of the case file. A notation is to be made in the narrative (in addition to the completion of the HCBS-1 Form) that the redetermination review was conducted.

Redetermination Summaries should:

- Include any changes in client status
- Document medication changes
- Document treatment changes
- Document new diagnoses
- Record diet changes
- Increase or decrease in strength
- Record the case manager's observations
- Expand on and support the ADL section of the assessment
- Describe the client's functional abilities and limitations
- Describe any assistance the client needs on a regular basis (e.g., supervision, standby assist, max assist)
- Describe who provides the assistance (waiver service or informal support?)
- Describe behaviors reported by client and collateral contact
- Elaborate on dependence issues, transfer, locomotion, dressing, eating, toileting, bathing, continence, communication and memory.
- Record statements made by client; always document in quotations
- Substantiate conclusions and judgments
- Link services to documented deficiencies: Explain how the waiver and each service provided meet the needs of the client

6.3.6: Case Narrative Documentation Requirements

The *Case Management Home Visit* tool (MW-1) and written narratives shall combine to provide the following:

A brief statement or listing of the activities performed, including:

- Face to Face Visits (monthly and as needed)
- Medicaid Eligibility (prior to the 1st of each month and as needed)
- Service Provider Billing is complete and verified as accurate (monthly)
- CM Signature/Initials (hand written in ink after each narrative entry. *CM can type their name and initial in ink or sign name in ink*)
- Information on all services received, both waiver and non-waiver (monthly and as needed)
- Health and Safety of the client (monthly)
    - If there is a safety issue noted, what was done to correct it? What was done to educate the client/family to help prevent injuries?
- Client/caregiver satisfaction of service (monthly)
- Benefits and Outcomes of services (monthly)
    - Example: homemaker services help to maintain a clean and sanitary environment and help delay/prevent client from being placed in a LTC facility. Each service should be addressed.
- Client's needs are being met (monthly)

- Client/Caregiver informed of available sources of support (as needed)
  - Is the client aware of other services or agencies that can be utilized to help maintain them in the home? Example: travel vouchers are available from AMA to assist with the cost of transportation to medical appointments.
- Freedom of choice (Initial and as needed)
- Breaks in service, Example: Hospital discharge or admission, out of town visit, short term loss of eligibility. (as needed)
- Supervisory Visits (every 60 days and as needed)
- Follow-up to problems (as needed)
- Missed/attempted visits by case manager (as needed)
- Missed/attempted visits by the service providers (as needed)
- POC is discussed with the Client/Caregiver (as needed)
- SPA is discussed with the Client/Caregiver (as needed)
- 10-day Notice of Action MW-30 (as needed)
- Case Review and Fair Hearing Instructions E&D-6R (Initial and as needed)
- The client/caregiver is given the complaint/grievance policy and procedures (initial assessment, redeterminations and as needed).
- The client /caregiver are given their rights and responsibilities (initial assessment, redeterminations and as needed).
- A summary of the 12 month (redetermination) review (annually)

6.3.7: Late Entries

Anything billed for on the Case Management time log but not documented in the narratives will require a late entry note in the case file.

Examples include:

1. Blank boxes or information left off the Home Visit Tool.
2. Redetermination summaries not documented in narratives.
3. Missed Visits or Supervisory Reports that are in the file but not documented as having been received.
4. DSP billing and Medicaid eligibility that was verified but not documented.

The documentation should be clearly identified as "LATE ENTRY" with the current date reflected. The narrative will explain the action taken and the date it was performed.

Items not requiring a late entry:

1. Initial Assessment not in current file. (Move from old file to new file)
2. Forms not complete or outdated (Such as Meals Assessment, FOC, Rights/Resp. etc.)
3. Missing SVR's or MVR's (Request from DSP, review, document and file)
4. CP not signed (Get CP signed and document)
5. Medical's not matching
6. Incorrect signatures on forms (Not HV Tools- these cannot be re-done)

For the above errors, make the correction needed, obtain new signatures, request missing items, file the new/corrected documents, and then document the date completed in the narrative.

Section 6.4: Interruption/Termination of Waiver Services

An interruption of waiver services may occur if a client is admitted to the hospital or if a situation occurs which requires a temporary hold of services. In some instances, a termination of waiver services may occur depending upon the outcome of the temporary interruption of services.

Section 6.5: Waiver Slot Retention after Termination and Re-Entry

An individual who is approved for services through the waiver program will retain the waiver slot for the remainder of the fiscal year in which the slot was allocated. If an individual who terminates the program is re-approved for admission to the waiver during the same fiscal year, a new slot will not be needed.

Section 6.6: Parents, Guardians & Relatives Providing Waiver Services*

Services provided by relatives or friends may be covered only if relatives or friends meet qualifications for providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to ensure that payment is made to the relatives or friends as providers only in return for personal care services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the case management file showing that the family member is a qualified provider and the lack of other qualified providers in remote areas. The case manager will conduct an initial assessment of qualified providers in the area of which the client will be informed. The case manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The case manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for clients living in a remote area.

***Exception: The above does not apply to individuals enrolled in the *Personal Choices* Program**

Section 6.7: Services to Clients in Hospitals

A hospitalized client is still considered active and therefore the case management activities can be performed in the hospital as long as it relates to discharge planning. The case manager may work with a hospital social worker for the purpose of discharge planning. All "face-to-face" visits done in the hospital must be documented. Any telephone conversations with family members or hospital staff must be documented to ensure continuity of service provision. This situation often requires additional time and effort for the case manager, and such contact is encouraged.

Section 6.8: Services to Clients in Boarding Homes

Clients enrolled in ADSS waiver programs are not allowed to receive services in boarding homes. Please contact ADSS for further instructions if a waiver client moves from a private home setting to a boarding home.

Section 6.9: Services to Clients in Foster Homes

Individuals in foster homes may receive waiver services providing the facility is licensed by a recognized agency (such as DHR). The services provided to the client in a foster home are for the client only. For example, a worker providing homemaker services may only clean the client's room and not common areas accessed by other residents such as the bathroom or kitchen.

Section 6.10: Services to Clients Who Receive Hospice

Hospice services and E&D waiver services may be provided at the same time only if the hospice service is being covered by Medicare and no duplication of service exists. If the individual is receiving hospice services through Medicaid, the client cannot receive services under the E&D waiver program.

Section 6.11: Services to Clients with Infectious/Contagious Diseases

When an applicant is confirmed by his physician to have an infectious disease, it is the option of the AAA/COG/RPC as to whether or not they will enroll the client into a waiver program. If the decision is made to provide services, the DSP should be contacted to ascertain their policy on delivering care to individuals who have infectious diseases. All direct service workers performing services must have training on contact safety. If the contractor position is that they will not provide care, the AAA/COG/RPC should identify another entity to be utilized.

If an enrolled client is diagnosed with a contagious disease, services should be placed on hold until the physician has provided confirmation that it is safe for workers to provide care. If services are placed on hold, ADSS will waive the face-to-face requirement for both the assessment and the monthly visits during the time the client is on hold. The case managers should maintain contact with the client by telephone.

Section 6.12: Services to Clients in Dangerous Environments

Services cannot be provided in environments that threaten physical harm to service providers or case managers. Applications should not be taken on such cases unless and until other living arrangements are made. Suspension of services to active clients whose environment becomes dangerous is appropriate unless and until other living arrangements are made. If the client is not making a reasonable effort to correct the situation, a consult with ADSS is required to determine if termination of the case is appropriate under the rule of non-cooperation.

The case manager should always place the health and safety of the client, caregiver, service provider and themselves at the forefront. The case manager is to leave the client's home at any time there is an immediate threat to their safety.

Suspected illegal drug activity must be reported to ADSS, possibly DHR and/or law enforcement. Immediate suspension/termination of services may be warranted depending upon the situation. Contact ADSS for instructions on how to proceed.

Section 6.13: Firearms in the Home

It is not permissible to disallow a client his or her 2nd Amendment right to bear arms. However, under no circumstances should the welfare of the client, caregiver, case manager, DSP or others be placed at risk due to firearm possession. If it is determined that health and safety is at risk, termination is warranted. Referral to DHR or even the local law enforcement agency may be advisable depending upon the situation.

In some instances, a client may be asked to place the firearm out of sight during service times. If unable to resolve a situation with the client/caregiver, the case manager and/or DSP may choose to not provide services.

Section 6.14: Health and Welfare

CMS requires assurances that with waiver services, the individual can continue in the community without jeopardizing his/her health and safety. It is the case manager's responsibility to take appropriate action when the health and safety of a client is determined to be at risk. All efforts to resolve the issue must be documented and the resolution must be noted.

Section 6.15: Abuse/Neglect/Exploitation

Under Alabama law, suspicions of abuse or neglect must be reported to the Department of Human Resources (DHR). Case managers should notify the local DHR office immediately by telephone and follow up in writing. Such an occurrence should be documented in the case record along with follow-up. **A report is also submitted to ADSS via the Critical Incident Reporting System.**

Section 6.16: Confidentiality

In the process of the assessment and the subsequent case management activities, the case manager will obtain knowledge of the client's personal, financial and medical conditions. The confidentiality of this information must be protected at all times. Case Managers should be trained by the AAA on HIPAA policies and they
are required to follow HIPAA guidelines regarding protected health information.

There are two (2) situations when the release of information is considered justified; in the process of obtaining information to ascertain or continue the eligibility of the client for services or when another agency has asked for information as a condition of delivering services. In both cases, information released should be limited to what is necessary.

Providers entering the home to perform services through this program should be given only the personal and medical information that is judged to be applicable to effective delivery of care.

Any request for information that fall outside of these two examples should be referred to the client. At any time, they may consent to have certain information released and the case manager should follow established guidelines.

At no time, should a case manager state the name, address or any other identifying information to the general public. Case examples cited at professional conferences or in professional literature should carry no identifying information.

Section 6.17: Sixty Day Reviews (Supervisory Visits)

Supervision of Personal Care Workers (PCW) by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) shall be conducted at a minimum of every 60 days on-site (client's place of residence) for each client. The supervisory visits **must** be documented in the individual client record and reported to the AAA/COG/RPC. If a 60-day supervisory visit report is late/missing, the case manager **must** provide documentation indicating they are aware of the problem and what they are doing to try to resolve it. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicions of substandard performances by the PCW.

Additional information about the sixty (60) day review and other nursing supervision requirements can be found in the "Scope of Services".

Section 6.18: Changes in Service

Section 6.18.1 - Changes in Services Within an Authorization Period

Services may be initiated or changed at any time within an authorization period to accommodate a client's changing needs. Any permanent change in waiver services necessitates a revision of the POC. The revised care plan must coincide with the narrative and the case manager must prepare a new Service Provider Authorization form (MW-13). The revised care plan must be signed by the client/representative.

Section 6.18.2 - Temporary Changes

The case manager should be immediately informed of any changes in services due to illness of workers, illness of clients, absence of workers, absence of clients, or other unpredictable incidences. All variations in the amounts of services actually delivered as compared to the POC is to be explained in the narratives. At times, the variance may not be reported to the case manager and is discovered upon receiving the billing invoice. The case manager is to contact the provider for explanation for the variation and to document the explanation in the narrative. **A new SPA is required for approved temporary changes. A narrative entry is also required. A new care plan is optional.**

Section 6.18.3 - Permanent Changes

Any increase or decrease to services added to the POC must be justified and clearly explained in the narrative. Each change should relate to a documentable modification in the client's physical or environmental condition. Change based solely at the request of the client/caregiver is not sanctioned.

Section 6.19: Transfers Within the Aging Network

Section 6.19.1 - Same AAA Region

If a client moves from one county to another **within the same** AAA/COG/RPC region, the only necessary action is to make the appropriate corrections in AIMS such as the correct address and county.

Section 6.19.2 - Different AAA Region

If an individual receiving services on one of the waiver programs operated by ADSSS moves from one region to another within the state, certain procedures must be followed in order for each AAA to receive the appropriate payment. The transfer will need to be coordinated between the transferring AAA and the receiving AAA. If the transfer occurs at any time other than the first day of the month, each AAA must split bill the time during the affected month in order to receive payment for case management services provided.

A new medical is not required when a transfer occurs. The following information should be coordinated:

TRANSFERING AGENCY:

The transferring agency will submit the original AIMS-2 with transfer information to the receiving AAA/COG/RPC; this should include the date of transfer, the agency and the county the client is transferring into. A copy of the AIMS-2 must be maintained in the original agency case file. The

transferring case manager should go to the AIMS program and look in the "Client Information" tab that belongs to the client to be transferred. Click on the "Agency" folder scroll button and click on the name of the agency the client is being transferred to. **Be sure to save your selection.** The original copies of all forms and narratives should remain in the original case file (held by the original agency) with copies sent to the new/receiving agency to facilitate the arrangement of services and a continuity of care. Please DO NOT submit an AIMS-2 to ADSS for processing; this will cause the client to be **terminated** from the program.

RECEIVING AGENCY:
The new/receiving AAA/COG/RPC should immediately contact the client to ascertain if services are still appropriate, in what form, amount and to reflect the current social situation of the client. A new reassessment (HCBS, pages 1, 2 & 4) is then completed and held in the client's case file. **(Do not submit to ADSS)** All noted changes should be indicated on the reassessment such as: change of address, county, phone numbers, etc. It is not necessary for the receiving agency to complete another Medical Form unless the condition of the client has changed sufficiently to warrant an adjustment in the level of care or the client has a new physician. Any changes should be handled on a new Care Plan. The reassessment, including a copy of the Medical Form from the transferring agency will be kept in the client's case file and must be accessible to ADSS, AMA, and CMS for Quality Assurance purposes. This application needs to be marked: *"Reassessment due to transfer" and be dated with the transfer date".*

(If a slot is not available in AIMS at the receiving agency, call ADSS for a manual transfer to be done. ADSS will resolve the slot issues as needed to insure your agency maintains its' assigned slot levels.)

Section 6.19.3 - Nursing Home Transfer to a Waiver Program
Nursing home to waiver transfers must be processed for services to begin on the first of the next month. This process will ensure proper payment to the AAA rendering services to waiver recipients.

The Medicaid District Office (DO) must be notified by the 15th of the month prior to the recipient's transfer to allow the DO worker time to perform required system changes. Case managers should work closely with the DO to ensure changes are made prior to services being rendered.

For waiver participants who are not certified by the Medicaid District Office, transfers can occur as soon as practical. For example, waiver participants certified by the Social Security Administration can be transferred anytime during the month.

Section 6.20: Transfer to Different Waiver Program

An individual currently being served through one of the Medicaid waiver programs may be granted approval to transfer to another waiver program if their condition is such that the current waiver is not meeting their needs and admission to an institution is eminent if another waiver is not an option to meet their needs in the community.

An individual may be appropriate for transfer to another waiver program if they would be able to access services not available in their current waiver program. Documentation must support the need to transfer from one waiver to another waiver.

Transfers to waiver programs operated by other State Agencies will require approval of Medicaid. A letter of request, medical documentation, case narratives, and other requested information will be submitted to the appropriate Medicaid program manager for review and final approval.

Section 6.21: Employment of Waiver Recipients

Employment is permissible by a recipient of waiver services providing wages or salary does not terminate SSI and the individual continues to meet the level of care requirements. Each individual situation should be carefully evaluated and not automatically terminated. Waiver clients are not required to be homebound to be on this program.

As you evaluate each individual situation, please keep in mind that Rehabilitation and Education are not services of the waiver programs. Persons whose main needs are in those areas should be referred to the appropriate agency or organizations.

Section 6.22: Client Rights and Responsibilities

RIGHTS:

- The client has the right to confidentiality concerning his/her personal affairs.
- The client has the right to be treated with dignity and respect.
- The client has the right to maintain his/her independence to the greatest degree possible.
- The client has the right to quality services delivered in a consistent and stable manner.
- The client has the right to express grievances and to appeal decisions made by agencies.
- The client has the right to be informed of resources available through the program.
- The client has the right to be informed of the limitations of the program.
- The client has the right of "Freedom of Choice".
- The client has the right to participate in the development of the POC.
- The client has the right to reject services and be informed of the consequences of such actions.

RESPONSIBILITIES:

- The client and his/her family have the responsibility to cooperate with the case manager and the in-home workers and treat them with respect.
- The client and his/her family have the responsibility to participate in the provision of care to the greatest extent possible.
- The client and his/her family have the responsibility to report changes in the client's situation to the case manager as soon as possible.
- The client and his/her family have the responsibility to be at home when services are scheduled or to notify the service provider prior to the service date.
- The client and his/her family have the responsibility to provide adequate food, personal and household supplies so that services may be performed.
- The client and his/her family have the responsibility to secure proper medical care to the greatest extent possible.
- The client and his/her family have the responsibility to report inadequate services to the case manager.
- The client and his/her family have the responsibility to sign verification of services only after ascertaining their accuracy.

Section 6.23: Complaints and Grievance/Critical Incidents

Case managers are responsible for explaining the procedures to clients and families/legal representatives regarding filing complaints and grievances. Case managers are to ensure that they are informed about their rights concerning abuse, neglect, and exploitation at least annually. DSPs must also have procedures in place that explains to clients the process on how to register a complaint. The DSP supervisor will investigate any complaints registered by a client against any DSP workers. Any action taken will be documented in the client's record. If the client is dissatisfied with the action taken by the provider they should forward their complaint to appropriate agency and/or AMA.

Complaints/critical incidents are to be entered into the electronic Incident Reporting System to ADSS. Each incident is submitted to Medicaid and is followed through resolution.

Part 7: Terminations/Appeals

Section 7.1: Termination of Waiver Services

A. Services must be officially terminated if a client no longer requires or becomes ineligible to receive the service. Waiver services may be terminated at any time during a waiver approval period. Termination requires prior approval from the Lead Case Manager and or ADSS.

B. When a change in the client's needs suggests a change in services included in the client's POC, the case manager will discuss the proposed change with the client, responsible party, and/or significant other before implementation and/or before issuing a written advance notice. The discussion will include an explanation of the reason for the change, impact of the change, and an agreement, if possible, of the client, responsible party, and/or significant other to the change.

C. When services are suspended, terminated, or reduced to coincide with the client's justifiable need, the service definition, and/or eligibility for the service, written advance notice (Notice of Action Form) is required at least ten calendar days before the effective date of action, with the following exceptions:
   1. A written statement is provided by the client, responsible party, and/or significant other which specifies that services are no longer needed or wanted and/or there is an agreement to reduced, suspended, or terminated services;
   2. The client moves to another county and waiver services are being provided in that county;
   3. The client transfers to another waiver program;
   4. The client moves out of state;
   5. The client dies;
   6. The client moved and left no forwarding address and his or her whereabouts are unknown as verified by return of agency mail;
   7. The client enters a nursing home, hospital, or other facility where services cannot be provided according to policy;
   8. The client is no longer financially eligible; and,
   9. The client, responsible party, and/or significant other requests by telephone that services be reduced, suspended, or terminated.

The above exceptions are not a definitive list. If an unprecedented situation occurs ADSS should be contacted.

D. Services as on the POC at the time the notice was given are to be continued from the date of the written notice and the effective date of the adverse action unless:
   1. Providing services results in a danger to the health and safety of the service provider(s);
   2. Providing services is against the expressed wishes of the client, responsible party, and/or significant other;
   3. There is no willing provider available.

Noncompliant Client

A. If a client, responsible party, and/or significant other refuses to cooperate with the Medicaid waiver program and all alternatives (i.e., counseling, personal contacts, referrals to interagency team staffing, case manager/supervisory visits, etc.) have been exhausted, termination of the waiver services and/or termination from the program may be appropriate.

B. Examples of noncompliance include but are not limited to:
   1. Repeated refusal to cooperate with providers and/or case managers;
   2. Repeated incidences of noncompliance with the POC;

3. Physical abuse, sexual harassment, or repeated verbal abuse toward provider and/or case manager;
4. Conduct which adversely impacts the program's ability to ensure service provision or to ensure the client's health, safety, and welfare. This may include refusal to allow workers access into the home to provide services, repeated unscheduled absences from the home during scheduled service hours, refusing to sign program forms, not allowing workers to perform authorized services or other conduct that puts the client, case manager, or worker at risk. This conduct causes an unreasonable care environment that interferes with the delivery of service.

C. If termination of a waiver service for noncompliance is being considered, the following must occur:
   1. All efforts made in working with the client, responsible party, and/or significant other must be carefully documented;
   2. Termination of services must be prior approved by authorized staff at ADSS;
   3. Client must be notified of termination of service;
   4. The service contract must be sent to the provider to terminate services.
   5. The client, responsible party, and/or significant other must be notified in writing by certified mail of the program requirements, advised of potential consequences of continued noncompliance and given an opportunity to remedy the circumstances. The letter must have the authorized staff at ADSS approval prior to sending to the client.

Section 7.2 TERMINATION PROCEDURE

Section 7.2.1 - Initial Process

All efforts made in working with the client, responsible party, and/or significant other must be fully documented. All instances of behavior that appear to be examples of or precursors to non-cooperation should be clearly detailed in the case narrative.

1. INVESTIGATION - Upon receipt of a report of an incident of non-cooperation, the case manager will obtain statements from the involved parties including the client, the caregiver, and the worker. The process of investigation should be completely recorded in the case record. Whenever the in-home worker is in a position to observe non-cooperative behavior, a statement should be obtained and placed in the record. Whenever the in-home worker is involved in the occurrence, a copy of the contractor's incident report should be obtained and placed in the record. If law enforcement is involved, obtain a copy of the police report. In most cases a report shall also be submitted to ADSS via the *Incident Reporting System*.

2. NOTIFICATION - Upon verification of non-cooperative behavior, the case manager should meet with the involved parties to try to resolve the matter. If the decision is made to continue services, the meeting should be followed with **notification in writing** identifying the unacceptable behavior, the agreement reached by the parties and the consequences (possible termination) for recurrences. If possible, get the involved parties to sign a statement to indicate an acknowledgement of the outcome of continued inappropriate behavior, and then send copies to the involved. If there is any question as to the ability of the client to understand the behavior or the consequences, a responsible person must also be informed and his/her signature obtained.

(The above certified letter **MUST** have ADSS approval prior to sending to the client.)

If the health/safety of the healthcare professional is in question, immediate termination is appropriate. DO NOT place anyone at risk by continuing services. Contact ADSS ASAP for instruction. The ten (10) day *Notice of Action* is waived.

3. FOLLOW-UP - If care provision has continued and a subsequent violation occurs, notification of termination is sent. Cases being terminated require that a MW-30, "Notice of Action" be issued to the client and his/her physician notifying them that Waiver services are to be terminated, with the following exceptions:
   a. A written statement is provided by the client, responsible party, and/or significant other who specify that services are no longer needed or wanted and/or there is an agreement to reduce, suspend, or terminate services.
   b. The client has died.
   c. The client moved and left no forwarding address and his or her whereabouts are unknown as verified by return of agency mail.
   d. The client moves to another county and waiver services are not being provided in that county.
   e. The client transfers to another waiver program.
   f. The client has transferred to another AAA/COG/RPC and continues to receive services.
   g. The client enters a nursing home, hospital, or other facility where services cannot be provided according to policy.
   h. The client losses financial eligibility.
   i. The client, responsible party, and/or significant other request by telephone that services be reduced, suspended or terminated.

The above is NOT a definitive list. If an unprecedented situation occurs, ADSS should be contacted. All terminations require prior approval from the Lead Case Manager.

4. 10-DAY NOTICE
   a. When services have been reduced or terminated, the case manager should send a 10-day advance notice (Notice of Action Form) to the client prior to the reduction or termination of services. When the client receives this notice, they have 10 days following the effective date of action taken to request an informal conference in writing.
   b. "Appeal and Fair Hearing Instructions" form MW-6R must accompany the 10-day notice.

Section 7.2.2 - Action Steps

The information below describes the action steps needed based on the reason for termination.

- **DEATH, ADMISSION TO A NURSING HOME OR MOVING OUT OF STATE**
  Upon notification of death, admission into a nursing home, leaving the state, or other reason for termination, the case manager will submit the original AIMS-2 to ADSS for processing to Medicaid, be sure to indicate the reason for termination. The effective date of termination will be the date of the change in these instances. Always be sure that termination dates are correct. Once processed, only Medicaid can make a correction and that is per written request by ADSS.

- **FINANCIAL INELIGIBILITY**
  If the case is terminated because of SSI or Sup ineligibility, services will be terminated on the last day of the last month of Medicaid coverage. If the client becomes financial ineligible, and you know that it is a short term problem, DO NOT discharge the client. Place the services on hold, and resume those services after financial eligibility is reestablished. The client may reapply as

300% deeming. DO NOT terminate. Call or email the ADSS nurse reviewer and request a *Waiver Slot Confirmation Form*. Be sure to document all actions in the narratives.

- **CLIENT REQUEST**
  At any time during active status, a client may request that his/her case be closed. It is advisable that the case manager secures a written statement to that effect and document in the case narrative the reason(s) such a decision was made. This policy also applies to new applicants not yet approved for wavier services.

- **MEDICAL INELIGIBILITY**
  In the event that a client's condition improves to the point that services are no longer required to prevent institutionalization, or the case manager receives information that the client's condition was not accurately represented in the assessment, the case manager should contact the nurse reviewer at ADSS for instructions on how to proceed.

  A case may also be terminated when a client meets the objectives as stated on the Care Plan. If the client can adequately perform the activities specified on the Care Plan or the informal caregiver can meet the client's needs without waiver support, the services may no longer be needed. The case manager should document specific examples of task performance and any observations may during visits. The MW-30 "Notice of Action", and MW-6R "Appeal and Fair Hearing Instructions", must be given to the client/caregiver as notification of action and the right of appeal.

- Make referrals to other more appropriate services when indicated.

Section 7.3: Appeal Request

The client has thirty (30) days from the effective date of the action to request an appeal. The client may notify ADSS in writing giving the reason for the dissatisfaction and ask for an appeal. At the appeal meeting, the client will have the opportunity to present additional information in support of their case. The client may present the information or may be represented by a friend, relative, attorney or other spokesperson of their choice.

If the client wishes to continue services while the case is in appeal status, a written request must be received by ADSS within ten **(10)** days of the effective date of The Notice of Action. The client should also notify their case manager that they wish to continue services.

If services are continued pending the outcome of the appeal and the decision is not in the client's favor, AMA may recover from the recipient or sponsor, the costs of all services paid after the initial effective date.

Section 7.4: Fair Hearings Request

REQUEST FOR A FAIR HEARING

AMA will notify the client of the decision of the appeal. If the client is still dissatisfied, a fair hearing may be requested. A written request for a hearing must be filed within thirty (30) days following the notification of the decision. He/she, his/her legally appointed representative or other authorized person must request the hearing and give a correct mailing address. If the request for the hearing is made by someone other than the client, the client must make a definite statement that he/she has been

authorized to do so by the client for whom the hearing is being requested. Information about the hearing will be forwarded and plans will be made for the hearing.

AMA need not grant a request for a hearing if the sole issue is a federal or state law or policy which requires an automatic change adversely affecting some or all recipients.

MEDICAID ELIGIBILITY DIVISION POLICIES AND PROCEDURES IN COMPLIANCE WITH CIVIL RIGHTS ACT OF 1964 AND SECTION 504 OF THE REHABILITATION ACT OF 1973.

STATE OF ALABAMA MEDICAID AGENCY
LTC Division-Project Development
501 DEXTER AVENUE
P. O. BOX 5624
MONTGOMERY, ALABAMA 36103-5624

(The client's slot must be held open until this process is completed.)

Part 8: Quality Improvement Services

Section 8.1: Overview

The Waiver Quality Assurance process is a coordinated, comprehensive and ongoing process that monitors and evaluates the Home and Community Based Waiver Programs. Quality assurance activities are conducted to ensure that AAA and the DSP comply with the requirements of the Home and Community Based Waiver documents.

Section 8.2: Provider Compliance Reviews

Monitoring Requirements

Policies and procedures are designed to ensure that the health and safety of recipients will be safeguarded.

Administrative and Case Management Assessments

Personnel meeting the qualifications outlined in the E&D waiver document, AMA Policies and Procedures manual and/or the ADSS Program Guide will conduct program QA assessments.

1. **ADSS Assessment Responsibilities**
   It is the responsibility of ADSS to perform annual and as needed program assessments consisting of the following:
   - Evaluation of the administrative functions at the AAA/COG/RPC and examination of a random sample of AAA/COG/RPC case records.
   - Field (in-home) visits to a random sample of clients' homes.
   - Assessment of Adult Day Health centers (as needed).
   - Assessment of DSPs (as needed).

   Evaluations will be based on adherence to policy contained in this manual, the E&D waiver document to include the Scopes of Services and to subsequent policy statements issued by ADSS and AMA. The ADSS personnel conducting the evaluations shall meet or exceed the qualifications for case managers as outlined in the "Scope of Services" under case management.

2. **AAA Assessment Responsibilities**
   It is the responsibility of the AAA to perform assessments of the DSPs who are contracted to provide services to clients in the waiver programs.

3. **Case File Assessments**
   It is the responsibility of the AAA to perform annual case manager case file assessments consisting of the following:
   The case manager supervisor or a case manager peer shall review 100% of all assigned client records utilizing the QPA-4 Peer/Supervisor Review Form. This process should be spread out over the course of the year allowing the reviewer time to assess all of the client case files. A portion of the records should be reviewed at least every 60 days. The case manager supervisor should get the case manager that is being reviewed to sign off on the form to indicate that he/she has seen the review. This will ensure that any deficiencies found will be addressed. The supervisor should also sign off to indicate that he/she is aware of the review and follow-up as needed. The completed QPA-4 shall be kept in the case file showing that the file was reviewed.

4. **Client Assessments**
   It is the responsibility of the AAA/COG/RPC to perform annual reviews (re-determination) of each client as detailed in chapter IV, section H of this program guide.

Section 8.3: Abuse, Neglect, or Exploitation

Under Alabama law, suspicions of abuse or neglect must be reported to the Department of Human Resources. Case managers should notify the local DHR office immediately by telephone and follow up in writing. Such an occurrence should be documented in the case record. Be sure there is documentation of follow-up.

Section 8.4: Complaints/ Incident Reports/ Incident Reporting System

Complaints and critical incidents are to be reported in the Gateway to Community Living web portal.

Incident Types	Timeframes
Physical Abuse	Immediate
Sexual Abuse	Immediate
Verbal Abuse	Immediate
Neglect	Immediate
Mistreatment	Immediate
Death	Immediate
Exploitation	24-hours
Moderate Injury	24-hours
Major Injury	24-hours
Natural Disaster	24-hours
Fire	24-hours
Fall	24-hours

Definitions

1. Physical Abuse-the infliction of physical pain, injury or the willful deprivation by a care giver or other person of necessary services to maintain physical and mental health.
2. Sexual Abuse -any conduct that is a crime as defined in Sections 13A-6-60 to 13A-6-70, inclusive of the Code of Alabama. Forms of sexual abuse include rape, incest, sodomy, and indecent exposure.
3. Verbal Abuse-the infliction of disparaging and angry outbursts such as name calling, blaming, or accusatory comments.
4. Neglect- the failure of a caregiver to provide food, shelter, clothing, medical services, or healthcare for the person unable to care for himself or herself; or the failure of the person to provide these basic needs for himself or herself when the failure is the result of the person's mental or physical inability.
5. Mistreatment-Actions that cause harm or create serious risk of harm whether intended or not, to a vulnerable person, by the caregiver or another person, or failure of a caregiver to satisfy the basic need or to protect the child or adult from harm.
6. Death-the permanent suspension of consciousness and the end of life.
7. Exploitation-the expenditure, diminution or use of the property, assets or resources of a person subject to protection under the provision of Sections 38-9-1 through 11, Code of Alabama, without the express voluntary consent of that person or legally authorized representative.

8. Moderate Injury-any observable and substantial impairment of a person's physical health such as temporary loss or impairment.
9. Major Injury-any observable and substantial impairment that results in permanent or temporary impairment, such as fractures, injury to internal organs, burns, or physical disfigurement of the body. These injuries may result in hospitalization.
10. Natural Disaster-the consequence of the combination of a natural hazard such as tornadoes, hurricanes, floods, power outages and winter weather.
11. Fire- a situation in which something such as a building or an area of land is destroyed or damaged by burning.
12. Fall- an incident that causes a person to drop suddenly from an up-right position which may result in harm.

All Medicaid approved providers who provide home and community-based services in Medicaid recipient's homes shall report incidents of abuse, neglect, and exploitation immediately to the Department of Human Resources, or law enforcement as required by the Alabama Adult Protective Services Act of 1976.
Other incidents must be reported according to the timeframes noted above. The following types of falls are to be reported:

- Falls witnessed by a worker that occurs while the worker is present in the home.
- Falls with moderate to severe injuries which require assistance from medical personnel.
- Excessive reports of falls from a client who has limited support or who lives alone.

Falls other than the ones noted above do not need to be reported through the portal.

It is required that all reports address the health and safety of a client.

The User Manual is provided in Appendix D.

Section 8.5: Background Checks

The statewide background check shall consist of the following personal identifiers: name, social security number, date of birth, driver's license number and/or applicable state identification card (i.e. non-driver's identification). Additionally, the authorized background check agency shall notify the potential employer if the background check reveals that an applicant is listed in the national sex offender public registry. Any services performed by a person in violation of the background checks are to be considered an overpayment and are recoupable.

The following criminal activities that will permanently disqualify a potential applicant from employment:

Applicants **must not** have convictions or pending charges for:

- Any crime of violence
- Any felony convictions as well as any pending felony arrests

The following are criminal convictions that would prevent an individual from being employed for the time period as specified below:

- Reckless endangerment in the past 5 years
- Stalking in the second degree in the past 5 years
- Criminal trespass in the first degree in the past 5 years
- Violating a protective order in the past 3 years

- Unlawful contact in the first degree in the past 3 years
- Criminal mischief in the first degree in the past 7 years
- Unlawful contact in the second degree in the past year

The following are the specifics related to the background checks:

- Statewide background checks are required for employees hired on or after October 1, 2007 and must be performed prior to the date of hire.
- Employees are not allowed to provide services until after the results of the background check have been received.
- Statewide background checks are not required for employees hired prior to October 1, 2007.
- Statewide background checks are required for all DSPs and for any employee who operates within the State of Alabama and has access to client records.
- Out-of-state corporate office employees are not required to have a background check done.
- Case Managers, Adult Day Health, and Home Delivered Meals providers are also required to undergo a background check.
- DSPs are responsible for conducting monthly checks of employees against the Medicaid Exclusion List.
- If an employee is terminated/leaves employment of the DSP and then is re-hired, a new background check must be obtained.
- Verification of the performance of background checks will be conducted during audit reviews.
- Failure to perform all components of the background check will result in recoupment of funds paid for services provided by the employee.

In addition to the background check, employers must also check the State of Alabama Nurse Aide Registry and previous employer references. DSPs are also required to check the OIG/Medicaid Exclusion List initially and on a monthly basis.

Section 8.6: TB Skin Tests

TB skin tests are required on an annual basis for personnel who have contact with waiver clients. The due date for the test to remain in compliance with the waiver standards is one year to date from when the TB test was read. Tests not completed prior to the due date will result in an audit finding and all services provided during the time of the lapse will be considered an overpayment which is recoupable.

An alternative TB screening checklist must be completed for employees who are allergic to the PPD test. For those employees, a baseline chest x-ray must be done with documentation from a physician indicating the employee does not have active TB. This documentation is to be maintained in the personnel file. Annually, thereafter, the employee is required to complete the Medicaid HCBS TB Screening Checklist. The checklist is to be completed and signed by the employee's supervisor.

Part 9: Audit Protocols

Section 9.1: Prospective Direct Service Provider

The information contained within this guide is to be used as the policy and procedure manual for auditing new and existing DSPs. The DSPs must be audited initially and on an ongoing basis to ensure that the Medicaid waiver requirements are being met as outlined in each Medicaid Waiver Document and as per the Scope of Services.

The AAA has the option to schedule the audit as "announced" or "unannounced." An announced visit requires the auditor to send prior notification of the scheduled audit to the DSP following the above guidelines. An unannounced audit requires no prior notification to the provider.

Prospective (New) DSP Direct Service Providers

The AAA must contact ADSS about all prospective providers to ensure they are in good standing before auditing them. A DSP that is on probation at another AAA or under investigation by AAA/ADSS/AMA, may be disapproved as a new provider until the probation/investigation is resolved.

The Prospective DSP must be found in compliance with all State and Federal waiver regulations before they provide direct services to clients. Therefore, the AAA must conduct an initial on-site visit to the Prospective DSP to assure compliance with all Waiver standards and regulations. The AAA may also provide orientation and education to the prospective DSP during the initial audit if needed.

Prior to the audit, the AAA is responsible for providing information and documents (Scope of Services etc.) to interested potential DSPs regarding the contracting and auditing processes and the rules/regulations they must meet and adhere to.

The Initial on-site visit/audit will consist of a review of the administrative requirements and agency personnel/staff records and their qualifications, as per the approved Waiver Scope of Services in order to determine if the DSP is in compliance with all Waiver regulations.

The AAA must send ADSS notification in writing of the results of this visit, to include a copy of the audit tools. ADSS must approve the audit report *before* a contract with the DSP is finalized/signed by the AAA. The AAA may also provide orientation and education to the prospective DSP if needed.

A. Employee File Requirements

All Prospective Provider Employee files must be reviewed as per AMA Memorandum dated February 11, 2008 which states:

"Statewide background checks will be required for all service employees and for any employee who operates within the State of Alabama and has access to client records. Branch office employees including non-visiting employees employed by DSPs who have access to client records are required to undergo background checks. Out-of-state corporate office employees will not be required to have a background done."

B. Administrative Review Requirements

The administrative review will consist of verification of:

1. Key staff i.e. administrator/supervisor *(present during audit)*

2. Organizational chart
3. Infection control policy/procedures
4. HIPAA policy
5. Complaint & Grievance policy
6. Policy and Procedures manual
7. Proof of current *Liability insurance*
8. In-service training plan (approved by AAA/ADSS)
9. Emergency plan
10. Annual operating budget
11. An appropriate place to conduct business:
    a. A room specified for the business must be separate from the personal dwelling area in the home. This room must be designated as the work space and can be closed off from the rest of the house.
    b. Furniture, equipment, and supplies shall be distinctly related to a business office. Bedroom furniture, clothing, gym equipment, etc. shall not be stored in this space.
    c. Business and confidential files must be kept in a locked file cabinet.
    d. Children, friends, or family members shall not utilize or occupy the office area unless they are employed by the business.
    e. A telephone line with a phone number different from the home residence is required. This number shall also have voicemail or an answering service.
    f. A sitting area must be included in the office space to meet with clients and business associates.
12. Other requirements per audit tools...

C. Personnel Review

The personnel review will consist of ensuring that employees:

1. Meet all *employee requirements* per the audit tools
2. Meet all *worker training requirements* per the audit tools
3. Have proof/copy of *Statewide, County & Municipalities Background* checks on all waiver employees per guidelines
4. Have proof/copy of *National Sex Offender Registry* checks per guidelines
5. Have proof/copy of *Alabama Certified Nurse Aide Registry* checks per guidelines
6. Meet other requirements per audit tools

D. Audit Findings

If the DSP is out of compliance of Waiver regulations/contract requirements, the AAA shall inform the DSP of the findings and provide information/education on how the DSP can correct/improve the area(s) that are not in compliance.

The Prospective DSP shall send the AAA a *Plan of Correction* (POC) which is forwarded to ADSS for approval. After ADSS approves the *Plan of Correction*, the DSP shall be given the opportunity to correct the findings. When ready, the DSP notifies the AAA and they will conduct a return audit/visit.

If after the 2nd audit/visit the DSP is still *out* of compliance and/or has problems identified, then the process stops and the Prospective DSP is notified in writing that the contract shall not be signed at this time. (If the AAA feels it is warranted, they *have the option to continue to train/educate the Prospective DSP to bring them into Waiver compliance.)*

E. Audit Requirements

A QA audit must be conducted with a new DSP during each of the first two years of operation. If there are no active clients at the time of the audit, the audit will consist of review of the administrative and personnel requirements.

Section 9.2: Prospective (NEW) Adult Day Health Provider

The AAA must contact ADSS about all prospective ADH providers to ensure they are in good standing before auditing them. A DSP that is on probation at another AAA or under investigation by AAA/ADSS/AMA, may be disapproved as a new provider until the probation/investigation is resolved.

The Prospective ADH DSP must be found in compliance with all State and Federal waiver regulations before they provide direct services to clients. Therefore, the AAA must conduct an initial on-site visit to the Prospective DSP to assure compliance with all Waiver standards and regulations. The AAA may also provide orientation and education to the prospective DSP during the initial audit if needed.

Prior to the audit, the AAA is responsible for providing information and documents (Scope of Services etc.) to interested potential ADH DSPs regarding the contracting and auditing processes and the rules/regulations they must meet and adhere to.

The Initial on-site visit/audit will consist of a review of the administrative requirements and agency personnel/staff records and their qualifications, as per the approved Waiver Scope of Services in order to determine if the DSP is in compliance with all Waiver regulations.
The AAA must send ADSS notification in writing of the results of this visit, to include a copy of the audit tools. ADSS must approve the audit report and Medicaid must conduct an on-site visit and provide approval *before* a contract with the DSP is finalized/signed by the AAA.

A. Employee File Requirements

All Prospective Provider Employee files must be reviewed as per AMA Memorandum dated February 11, 2008 which states:

"Statewide background checks will be required for all service employees and for any employee who operates within the State of Alabama and has access to client records. Branch office employees including non-visiting employees employed by DSPs who have access to client records are required to undergo background checks. Out-of-state corporate office employees will not be required to have a background done."

B. Administrative Review Requirements

The administrative review will consist of verification of:

1. Key staff i.e. administrator/supervisor *(present during audit)*
2. Organizational chart
3. Infection control policy/procedures
4. HIPAA policy
5. Complaint & Grievance policy
6. Policy and Procedures manual
7. Proof of current *Liability insurance*
8. In-service training plan (approved by AAA/ADSS)
9. Emergency plan
10. Annual operating budget
11. An appropriate place to conduct business:

a. A room specified for the business must be separate from the personal dwelling area in the home. This room must be designated as the work space and can be closed off from the rest of the house.
b. Furniture, equipment, and supplies shall be distinctly related to a business office. Bedroom furniture, clothing, gym equipment, etc. shall not be stored in this space.
c. Business and confidential files must be kept in a locked file cabinet.
d. Children, friends, or family members shall not utilize or occupy the office area unless they are employed by the business.
e. A telephone line with a phone number different from the home residence is required. This number shall also have voicemail or an answering service.
f. A sitting area must be included in the office space to meet with clients and business associates.

12. Other requirements per audit tool.

C. Personnel Review

The personnel review will consist of ensuring that employees:

1. Meet all *employee requirements* per the audit tools
2. Meet all *worker training requirements* per the audit tools
3. Have proof/copy of *Statewide, County & Municipalities Background* checks on all waiver employees per guidelines
4. Have proof/copy of *National Sex Offender Registry* checks per guidelines
5. Have proof/copy of *Alabama Certified Nurse Aide Registry* checks per guidelines
6. Meet other requirements per audit tools.

D. Audit Findings

If the DSP is out of compliance of Waiver regulations/contract requirements, the AAA shall inform the DSP of the findings and provide information/education on how the DSP can correct/improve the area(s) that are not in compliance.

The Prospective DSP shall send the AAA a *Plan of Correction* (POC) which is forwarded to ADSS for approval. After ADSS approves the *Plan of Correction*, the DSP shall be given the opportunity to correct the findings. When ready, the DSP notifies the AAA and they will conduct a return audit/visit.

If after the 2nd audit/visit the DSP is still *out* of compliance and/or has problems identified, then the process stops and the Prospective DSP is notified in writing that the contract shall not be signed at this time. (If the AAA feels it is warranted, they *have the option to continue to train/educate the Prospective DSP to bring them into Waiver compliance.)*

E. Medicaid Onsite Visit

If after ADSS review/approval, the Prospective ADH Provider is found to be *in* compliance of Waiver regulations/contract requirements, ADSS will forward all pertinent documentation concerning the Prospective ADH Provider to Medicaid LTC/QA Unit and request that an *initial on-site visit* be conducted within 30 days of submission of the request.

The Medicaid LTC/QA Unit shall conduct an *Initial Facility Audit*, following the ADH Standards Guidelines and the Scopes of Service. The *purpose* of this Initial Medicaid LTC/QA Unit on-site Visit/Audit is to inspect/Audit the Facility and ADH Provider Program (including vans, kitchen,

activities, etc.) to determine if the ADH E/D Waiver Requirements and Standards are in place to continue with the contracting process. The Medicaid LTC/QA Unit will notify ADSS of the audit findings.

After the Medicaid LTC/QA Unit on-site Visit/Audit, and upon receipt of AMA approval letter, the appropriate AAA shall be notified to sign the contract and ADSS shall notify Medicaid LTC/QA Unit upon completion of the contract process.

F. Audit Requirements

Audits will be conducted at least annually but may be more frequent during the first two years to ensure compliance with the waiver requirements. If there are no active clients at the time of the audit, the audit will consist of review of the administrative and personnel requirements.

Section 9.3: Existing Direct Service Providers DSP & ADH

(The following applies to both DSP and ADH providers herein referred to as DSP)
The AAA shall schedule routine on-site audits of DSPs as required by the waiver document. **Each DSP will receive an annual QA audit.**

A. Pre-Audit Steps for Announced Audits:

1. Call the DSP and schedule the visit.
2. Explain the process to the DSP, including what is needed for the audit and the time frame (months) to be audited. (*The minimum time frame to be audited shall consist of three months).*
3. Mail and/or fax a letter stating the date of the visit and other information regarding the audit, including a form on which the DSP is to list all Waiver clients served during the audit period, for the AAA conducting the audit; or the DSP has the option of printing a list of Waiver clients that were served during the period to be audited.
4. The DSP must have this completed client list available for review and an audit sample will be chosen from this list by the auditor, not the DSP.
5. The DSP is instructed to have billing available for the auditor for the time frame being reviewed.

B. The Audit Process:

The audit process will consist of the following:

1. Entrance Conference
2. Administrative Requirement Review
3. Personnel Records to include previous year in-service training review
4. Client Record Review
5. Billing Review
6. Exit conference

C. Files to Audit:

The file review will consist of the following number of files:

1. For employee files, audit a minimum of five (5) unless, there are fewer than 5 employees, then audit all. The audit is to include the RN supervisor. As part of the audit, all new hires (hired since last audit and currently visiting clients) shall be included. These count as part of the five (5) or fewer.

2. For client files, audit a minimum of ten (10) unless, there are fewer than 10 clients, then audit all. If the DSP has more than one hundred (100) clients, a 10% audit shall be conducted.
3. A client file needs to have a full 3 months of information in it before conducting a review. Less than 3 months of client file data may not provide enough information to determine the file status.

Note: The 530 waiver requires a 100% review of all employee files.

D. Expanded Audit:

The amount of audited records may/should be expanded based upon the number of major deficiencies noted during the audit. If the auditor determines that there is a significant amount and/or type of finding(s), a one-hundred percent (100%) review of the records is justified.

E. Missing Documentation:

The DSP must be given an opportunity to produce missing documentation during the time while the auditor is present at the DSP office. The DSP will *not* have additional opportunity to correct deficiencies found during an *announced* visit, as ample time was provided for the DSP to prepare. Examples of such deficiencies are, but not limited to, missing results of TB testing, misplaced personnel paperwork, missing supervisory visits, etc.

Depending on the findings during an unannounced audit, the DSP shall be provided no more than twenty-four (24) hours, or the end of the next business day, to provide the auditor any missing documentation discovered during the audit. (Examples provided above).

F. Exit Conference:

The auditor will discuss the preliminary findings with the DSP during the exit conference along with any recommendations made by the AAA; but, the DSP must be reminded that ADSS will review the audit and give final recommendations. Depending on the nature of any discrepancies found and the seriousness of those findings, the auditor can make recommendations for corrections.

After ADSS review/approval, the AAA shall provide the DSP a detailed/bulleted copy of the findings via letter; however, copies of the audit tools are not to be provided to the DSP. ADSS will issue guidance on the steps to be taken by the AAA to resolve identified issues.

On an announced audit, the DSP must have all pertinent staff present during the exit conference including the office manager, supervisory nurse and local administrator. Absences of the required staff from the exit conference could result in termination of the contract.

Section 9.4: Plan of Correction

When a *Plan of Correction* (POC) is required, the DSP has 15 working days from the receipt of the notification letter to submit the *plan* to the AAA. The AAA Lead Auditor must review the plan for correctness prior to forwarding it to ADSS for final review and approval.

The *Plan of Correction* must address each area of non-compliance, the plan for correcting each area and identify the DSP personnel responsible for ensuring the issues are monitored/corrected.

ADSS will review the *Plan of Correction* and a written response will be sent to the AAA indicating whether the *Plan of Correction* is acceptable or unacceptable.

If the plan meets the waiver requirements a letter will be mailed by the AAA to the DSP stating that it is acceptable. The acceptance letter may include the following language:

> *"Your plan of correction for the _____Waiver Audit for FY___ has been reviewed and accepted. To ensure continued compliance an Audit/Visit may be conducted at your facility annually. You may be notified in writing of your next scheduled on-site Audit. However, the AAA/ADSS reserves the right to conduct an unscheduled on-site visit to audit any/all Waiver documentation, should the need arise."*

If the plan is unacceptable, the AAA will contact the DSP by telephone, or e-mail to discuss concerns with the plan. The AAA shall offer the DSP in writing the opportunity to correct problems and submit another *Plan of Correction* within 15 working days from the date of the telephone call or email. ADSS shall be copied on the memorandum to the DSP.

Upon receipt of the second *Plan of Correction*, a determination will be made as to whether the *Plan of Correction* is acceptable or unacceptable. Again this is determined by staff at ADSS. If it is acceptable, a letter stating such is sent to the AAA and the AAA follows up with a letter to the DSP.

If the plan is not received in fifteen (15) working days and/or the plan is unacceptable, ADSS shall follow agency procedures regarding non-compliance and notify the AAA of the results. Based upon official notification, the AAA shall act according to the recommendations of ADSS regarding the vendor.

In order to ensure statewide uniformity in the treatment of vendors, the AAA may not act on their own without ADSS approval. ADSS recommendations may include probation, recoupment and/or withholding of payments to the AAA/DSP or termination of the DSP from waiver program participation.

Section 9.5: Follow-Up Visits

Three (3) month follow-up visits shall occur depending on the seriousness of the findings noted during the audit. If there is a major deficiency in the majority of the records in one audit tool area, a follow-up visit is required. If major deficiencies in two or more of the four audit tool areas *(Administrative, Personnel Record Audit, Client Record Audit, and/or Billing)* are found, a follow-up visit is required. During the follow-up visit, the auditor shall review the *Plan of Correction* and monitor the DSP's current documentation ensuring that the *Plan of Correction* is being implemented.
(Findings in a majority of records, for example client files, constitutes/adds up to a major deficiency and a follow-up visit is required.)

A three (3) or six (6) month follow-up audit shall consist of a review of the same records that had non-compliant areas during the initial audit, but only if those areas are correctable.

For example:
Background checks or TB skin tests were not performed prior to client/case file contact. If the initial finding was something that can't be corrected, such as in this case where the test or check wasn't done prior to client/case file contact, the follow-up audit can't penalize the DSP a 2nd time for the same exact finding. The auditor would look for current checks/tests to see if the issues in this file is now resolved.

Supervisory visits not present in the file or not done timely. Are supervisory visits now being done within 60 days?

A complete/current copy of the HCBS application (to include the POC) is present in the client/patient file. Is there one in the file on the follow-up visit?

In the files being reexamined, the auditor is to revisit only the previously non-compliant areas. Do not fill out an entire new tool.

In the case of personnel files, the audit shall consist of those that were non-compliant plus however many it takes to total five (5) records. Example: 3 personnel records were reexamined due to non-compliance, another 2 should be looked at to total 5 records, unless there are fewer than 5 employees, then audit all.

In the case of client files, the audit shall consist of those that were non-compliant plus however many it takes to total ten (10) records. Example: 6 case files were reexamined due to non-compliance, another 4 should be looked at to total 10 records, unless there are fewer than 10 clients, then audit all.

An exit conference shall be held with the DSP following the same procedures identified previously. The time clock for the three (3) month follow-up period shall start upon notification to the DSP, not three (3) months from the date of the original audit. Do not review a time period prior to this as the DSP has not had a chance to correct the deficiencies.

The AAA shall notify the DSP of when (what month) the three (3) month follow-up visit will occur, per ADSS instructions. The AAA is expected to notify the DSP of the ADSS decision within one or two weeks.

Section 9.6: Probation

If major deficiencies are found in three of the four audit areas, in a majority of the records audited, the DSP, with ADSS approval, shall be placed on probationary status.
The four areas that constitute probationary status include:

- Provider Administrative Requirements; some examples include: Staffing, Liability Insurance, Policies and all other Administrative Requirements as per the respective waiver program,
- Personnel Requirements (in the Personnel Records) for each of the staff, for example: TB skin tests, training, registry requirements, supervisory reports, and all other Personnel Requirements per the respective waiver program,
- Waiver Client Record Audit (Including all required documentation and record keeping requirements, per the respective waiver program,
- Billing; for example: billing for services not rendered,
- **Or** if the auditor determines that health and safety is being compromised.

(See *Health and Safety Section for* steps to follow if this occurs).

If any of the above reasons for probation are identified the auditor, upon return to the office, will discuss/audit findings, documentation and recommendations with auditor's supervisor or designated staff person and ADSS staff. If all concur, the DSP shall be placed on a six (6) month *probationary* status. (The DSP has already received a verbal account of the non-compliant areas found during the audit in the exit conference. And at that point, the DSP has been informed of their right to appeal the decision or findings).

A letter from ADSS will instruct the AAA to inform the DSP of the six (6) month *probationary* period; detailing the non-compliance areas noted during the audit, recommendations, any recoupment, if applicable, and the terms of the *probationary* period. (The DSP shall be informed of their right to appeal the decision or findings and to request further training from the AAA.).
The time clock for the six (6) month probationary follow-up period shall start upon notification to the DSP. The six (6) months starts from the **date of a decision by ADSS**, not six (6) months from the date of the original audit. The AAA shall notify the DSP of when (what month) the six (6) month probationary audit will occur, per ADSS instructions.
The AAA shall conduct a visit to the DSP after six (6) months.
If on the six (6) month probationary audit the DSP is found to have corrected the compliance issue(s), the DSP shall be placed on the annual QA audit schedule and *probationary* status will end.

If the DSP is not in compliance with waiver requirements at the time of the probationary audit, ADSS will review the documentation regarding the areas of non-compliance to determine if termination is warranted. If it is determined that the DSP contract should be terminated, ADSS will notify the AAA to begin the process of placing the clients with new providers. ADSS will also notify AMA that the DSP's contract to provide services to waiver participants is being terminated.

Section 9.7: Health and Safety

All health and safety violations require **immediate** action by the DSP. The AAA should discuss these violations with the DSP at the time of the exit conference and instruct the DSP to take corrective steps.
The following are *Health & Safety* violations:

- Missing and/or late TB tests per guidelines
- Missing and/or late National Sex Offender Registry checks per guidelines
- Missing and/or late Nurse Aide Registry checks per guidelines
- Missing and/or late Employee Background checks per guidelines
- Missing and/or late Fraud/Abuse Registry checks per guidelines
- RN/LPN not meeting waiver requirements i.e. education, prior working experience, licensure, etc. per guidelines
- Other per guidelines

In the event that a TB test or a background check has not been completed, the worker may not continue to see clients until the requirement is met.
Upon audit review, ADSS will request that a written *Plan of Correction* be obtained from the DSP covering the health and safety issue(s) within 15 working days of the AAA notice to the DSP. The *Plan of Correction* shall set forth time lines reasonable to correct the identified problems and steps the DSP has taken to ensure the problem will not recur. (If the AAA does not receive a timely acceptable *Plan of Correction*, the following shall be implemented.)
Depending upon the seriousness of the deficiencies, ADSS could require that:

- Immediate notification be made to the AAA case managers to make other arrangements for the provision of services for the client/s including notification to the client's caregiver/s or responsible person/s and contract with another DSP to ensure health and safety.
- The DSP be placed on immediate probation.
- Recommend termination of the contract due to health and safety issues identified.

The AAA/ADSS reserve the right to place the DSP on immediate probation and also reserve the right to review any/all DSP audit results to determine recommendations for termination of the contract due to health and safety issues identified.

Section 9.8: Retraining

Each DSP shall be provided an opportunity for retraining on the *Scope of Services* as outlined in each waiver document at the end of the audit. Each AAA shall handle its own method for retraining that may include individualized training for a particular DSP or may be provided in a DSP group training session.

Section 9.9: Recoupment

Medicaid regulations authorize recoupment for actions which result in an overpayment to any DSP. Any AAA can recoup funds previously paid to a DSP for several reasons that may include, but not limited to, billing errors, health & safety violations, non-compliance with the required initial visit, supervisory visits, or others as determined. Any recoupment will be determined by the AAA and ADSS and the DSP will have the right to appeal the recoupment amount. After ADSS review, the AAA shall notify the DSP of the recoupment amount, its appeal rights and insure the DSP is aware that only findings and recoupment issues can be appealed. Any questions or issues dealing with termination of a contract are separate from the recoupment appeal and shall not be taken up during the hearing process.

Section 9.10: Miscellaneous

- If a DSP is to be terminated at any point, for any reason, and wishes to contract in the future with the OA, they will have to complete the entire contracting process as a Prospective Provider.
- If a DSP opens a new office, an initial audit is required.
- If a DSP is bought out by another entity, an initial is not required if the office staff remains the same and the operation continues as before.
- If an out of state provider wishes to provide services in Alabama, they must open an office in-state in order to be considered as an eligible prospective provider.
- All reports must be submitted to ADSS within 30 days of the date the audit was conducted. ADSS shall respond to the AAA within 30 days of receipt of the report.
- **The AAA is responsible for educating/training the DSP of all policy changes/revisions and/or special notices issued by or through the ADSS. The AAA shall retain proof of training completed with the DSP of said policy revisions or notices.**

Part 10: Service Definitions and Requirements

Section 10.1: Service Definition Overview

Each service provided through the waiver programs has some overall basic requirements in addition to requirements that are more specific depending upon the program. Each section below provides the description of the service and related requirements.

Section 10.2: Service Rates

The average monthly cost of services was $865 per client in the 2016 fiscal year. Because this figure is based on a statewide average of all recipients, there will be occasions when Medicaid will approve a care plan specifying a higher cost with the assumption that other cases receiving less services will balance out the expenditures.

Emergency situations, such as increased disability of the client or decreased capability of the primary care giver may be justification to allow a temporary increase in services. This period of time should be sufficient to either arrange additional non-waiver resources, allow time for the situation to return to its prior need level, or until nursing home placement occurs. Justification for increased services should be clearly documented in the narrative of the case record.

The Medicaid Waiver programs are not designed to offer 24-hour care or 40-hour per week care. Such provision would be too costly to warrant approval. In those cases, in which the client needs supervision during absences of an employed caregiver, the case manager can arrange for a combination of State Plan Medicaid Services, HCBS waiver services, volunteer programs, and services paid for by the caregiver. This is also an appropriate case in which to consider adult day health care. If no such arrangements can be made, clients should be referred for nursing facility placement rather than E&D waiver recipient status.

Section 10.3: Adult Day Health

Per Medicaid 1915(c) HCBS Waiver: AL.00680R06.00 – Oct. 01, 2012, "Adult Day Health (ADH) is a service that provides Elderly and Disabled Waiver (EDW) clients with a variety of health, social, recreational, and support activities in a supervised group setting for four or more hours per day on a regular basis. Transportation between the individual's place of residence and the adult day health center will be provided as a component part of Adult Day Health Service. The cost of this transportation is included in the rate paid to providers of Adult Day Health Service."

Adult Day Health (ADH) is designed to maintain and promote the health status of the client through the provision of health related supportive activities that include individual and group therapeutic activities and social stimulation in an ADH center.

Adult Day Health services are provided within a maintenance model of care, which provides services that include the following health and social activities needed to ensure optimal functioning of the client:

- Health monitoring that includes supervising the client's medication and support in carrying out physician orders as needed.
- Monitoring vital signs as needed.
- Observing the functional level of the client and noting any changes in their physical condition.
- Supervising medication and observing for possible reaction.

- Teaching positive health care measures and encouraging self-care.
- Appropriately reporting to the caregiver and case manager any changes in the client's condition.
- Observe and assist the client to maintain good personal hygiene on a daily basis.
- Provide planned therapeutic activities to stimulate mental activity, communication and self-expression (these include reality orientation exercises, crafts, music, educational and cultural program, games, etc.).
- Provide a variety of opportunities for group socialization.
- Observe and assist the client with meal and eating.
- Develop a plan to address medical emergencies, fire, and natural disasters.
- Assistance in the development of self-care capabilities, personal hygiene, and social support services.
- Provision of nourishment appropriate to the hours in which the client is at the ADH center, but not equal to a full nutritional regime (3 meals per day). Specific diet requirements should be encouraged.

*ADH is **not** an entitlement; it is based on the needs of the individual client.*

Section 10.4: Assistive Technology

Assistive Technology includes devices, pieces of equipment or products that are modified, customized and used to increase, maintain or improve functional capabilities of individuals with disabilities. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an Assistive Technology device. Such services may include acquisitions, selection, design, fitting, customizing, adaptation, application, etc. Items reimbursed with waiver funds shall be in addition to any medical equipment furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. This service is necessary to prevent institutionalization or to assist an individual to transition from an institution to the ACT Waiver. All items shall meet applicable standards of manufacture, design and installation.

The objective of Assistive Technology service is to increase, maintain or improve functional capabilities for individuals with disabilities. It will also help ensure the health and safety for the recipient which enables them to function with greater independence in their current residence.
Businesses providing Assistive Technology services will possess a business license. Vendors are responsible for client orientation to the equipment.

Descriptions of the services to be provided are as follows:

1. The ACT Waiver program will pay for equipment when it is not covered under the regular State Plan and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records on each recipient must substantiate the need of services, must include all findings and information supporting medical necessity, and must detail all treatment provided. Vehicle modifications can only be authorized if it can be demonstrated that all Non-Emergency Transportation (NET) Services have been exhausted.

2. Assistive Technology includes pieces of equipment or products that are modified, customized and used to increase, maintain or improve functional capabilities individuals with disabilities.

3. The amount for this service is $15,000.00 per waiver recipient. Any expenditure in excess of $15,000.00 must be approved by the ACT State Coordinator and the Medicaid designated personnel.

4. The service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver. The service should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate.

Conduct of Services are as follows:

1. Assistive Technology must be ordered by the physician. It must be documented in the POC and case narrative. The case manager must have the prescription for Assistive Technology before requesting prior approval.

2. To obtain prior authorization numbers for this service, the case manager must submit a copy of the following documents:
   a. ACT Service Authorization Request Form.
   b. Price quotation list from the company supplying the recipient with equipment and specifying the description.
   c. A copy of the physician's prescription. Copies must be legible.

3. Assistive Technology must be prior authorized and approved by AMA or its designee and must be listed on the client's POC. The prior authorization packet is submitted to ADSS by the case manager and ADSS submits prior authorization requests using the ACT Service Authorization Request Form. Prior authorization is also required for Transitional Assistive Technology. ADSS will submit the prior authorization request packet to AMA Long Term Care for review and coordination.

4. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate.

5. Upon completion of the service, the client must sign and date a form acknowledging receipt of the service.

6. The case manager should secure an EOMB (Explanation of Medicare Benefits) from the vendor if Medicare can be applied towards purchase before the final payment will be processed for Assistive Technology. Explanation of benefits should also be secured if the recipient has other insurance.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount for this service is $15,000.00 per waiver recipient. Any expenditure in excess of $15,000.00 must be approved by the state coordinator and the Medicaid designated personnel.

Service Delivery Method: Provider managed
Provider Type: Vendor with a business license
Provider Qualifications: Business License
Other Standard: Vendor is responsible for orientation to the equipment.

Verification of Provider Qualifications Entity Responsible for Verification: Operating Agency
Frequency of Verification: As needed

Section 10.5: Case Management

Medicaid waiver case managers coordinate and integrate all services required in a participant's person centered service plan, link participants to needed services, and ensure that participants continue to receive and benefit from services. Waiver case managers enable participants to receive a full range of services needed due to a medical condition, in a planned, coordinated, efficient, effective manner. Case management is a comprehensive service comprised of specific tasks and activities designed to coordinate and integrate all other services required in the participant's service plan.

The components of case management are:

- Initial level of care (LOC) assessment
- Development of service plans including coordination of formal and informal supports
- Implementation of the service plan
- Assessment and care planning for discharge from institutionalization
- Annual and ongoing reassessments of LOC
- Periodic updates of service plans
- Monitoring the quality of home care community services
- Determining and monitoring the cost effectiveness of providing home and community-based services
- Information and assistance services
- Enhancement or termination of services based on need
- Administrative guidance
- Outreach through a process of creating awareness in the professional community and in the general public of the availability of services in order to identify and establish contact with those who are appropriate for the waiver programs.
- Referral through identifying which the persons in the community are in need of waiver services are making referrals to the appropriate program(s).
- Participation in Medicaid Fair Hearing process

Case management services for persons on Medicaid HCBS waivers are provided by certified case managers, as approved by ADSS. The 13 local AAAs serve as the single point of entry for the nursing facility Medicaid waivers. A case manager from the AAA is assigned to an applicant. After an applicant has been determined to meet the eligibility criteria and approved to receive nursing facility Medicaid waiver services, he or she may choose to retain his or her current AAA case manager or choose a non-AAA or independent case manager, for ongoing case management services.

Minimum qualifications for case managers are the following:

- All case management services provided must comply with the case management standards.
- The minimum educational and experience criteria for providing this service under the 530, ACT, and E&D waivers are:
    - A Bachelor of Arts or a Bachelor of Science degree, preferably, in a human services related field, from an accredited college or university; or
    - A registered nurse with current licensure

- All case managers must complete the CORE Training Modules before providing waiver case management services. Until a case manager has successfully completed the orientation, he or she may not work independently.
- All case managers must annually obtain at least 6 hours of training regarding case management services approved by ADSS under the HCBS waiver program.
- The case manager must have references which will be verified and documented in the personnel file. References must include statewide criminal background checks, previous employers, and the Nurse Aide Registry if applicable. All case managers must meet required training requirements per ADSS and AMA guidelines.

If ADSS identifies a systemic problem with a case manager's services, the case manager must obtain training on the topics recommended by ADSS.
Reimbursement of case management services, as defined in this manual, may not be made unless and until the client becomes eligible for waiver service. Case management service provided to individuals who are not eligible for ADSS waiver services will be reimbursed as an administrative service.

Section 10.5.1 - Ongoing Medicaid Home and Community-Based Services Waiver Case Management Standards

1. Case managers will maintain the highest professional and ethical standards in the conduct of their business.
2. Case managers will comply with all ADSS-issued manuals, as well as all federal, state, and local law, and all FSSA policy, rules, regulations and guidelines, including the *Health Insurance Portability and Accountability Act* (HIPAA).
3. New case managers will complete case manager orientation as approved by the ADSS prior to being eligible for Medicaid reimbursement. Completion of the modules is verified through completion of the final certification test. ADSS grades the test and issues certification for any score of 80% or higher.
4. Case managers are required to complete 6 hours of relevant in-service training annually. Required training hours are prorated in a case manager's first year and are in addition to new case manager orientation.
5. Individuals will choose their service provider, including their case manager, and have the right to change any provider, including their case manager.
6. Case managers will provide individuals a list of potential providers, furnished by the state of Alabama, including case managers and the services offered by each provider.
7. Case managers will provide, at a minimum but not limited to, an information guide to individuals on how to choose a provider and will assist the individual to evaluate potential service providers.
8. A maximum response time between implementation of the initial service plan and the first monitoring contact will be no more than 30 calendar days.
9. Case managers will have face-to-face contact with each individual at least one time per month to assess the quality and effectiveness of the service plan.
10. Case managers will document, in the chronological narrative, each contact with the individual and each contact with providers within seven days of activity.
11. Case manager documentation **must** show activity relevant to the service plan to be reimbursed.
12. Case managers will facilitate and monitor the formal and informal supports that are developed to maintain the individual's health and welfare in the community.
13. Case managers will provide each individual or guardian with clear and easy instructions for contacting the case manager or case manager agency. The case manager will also provide

additional information and procedures for individuals who may need assistance or have an emergency that occurs before or after business hours. This information will be located in the home in a location that is visible from the telephone.

14. Case managers will complete face-to-face Annual Assessments and update the service plan as needed, in collaboration with the individual, in a timely and appropriate manner to avoid gaps in service authorization, including assuring that the individual or guardian receives instructions on how to request an appeal through the Medicaid Fair Hearing process.
15. Case managers will communicate the individual's needs, strengths, and preferences to the support team.
16. Case managers will ensure that person centered planning is occurring on an ongoing basis.
17. Case managers will monitor the ongoing services to ensure that they reflect the service plan, including the individual's medication regime.
18. Case managers will base the service plan upon the individual's needs, strengths, and preferences.
19. Case managers will ensure that the individual and all providers have a current, comprehensive service plan that meets the needs of the individual.
20. Case managers will review and explain to the individual or guardian the services that will be provided, and the individual or their designated representative will sign the service plan to show understanding of, and agreement with, the plan.
21. Case managers will ensure that the individual or guardian, providers, and involved agencies have a copy of relevant documentation, as specified in the ***Waiver Case Management Manual,*** including instructions on how to request an appeal.
22. Case managers will obtain all required signatures on the service plan before submitting it to the State. The service plan will not be implemented prior to receiving State approval.
23. Case managers will document the quality; timeliness; and appropriateness of care, services, and products delivered by providers.
24. Case managers will initiate timely follow-up of identified problems, whether self-identified or referred by others. Critical or crisis issues, including incident reports, will be acted upon immediately, as specified by ADSS. All follow-up and resolution will be documented in the individual record.
25. Case managers will comply with all automation standards and requirements as prescribed by ADSS for documentation and processing of case management activities.
26. Case managers will maintain privacy and confidentiality of all individual records. No information will be released or shared with others without the individual or guardian's written consent.
27. Case managers will provide to the State upon request, ready access to all case manager documentation, either electronic or hard copy.
28. Case manager documentation will demonstrate that the safety and welfare of the individual are being monitored on a regular basis.

Section 10.6: Companion

Companion Service is non-medical assistance, observation, supervision and socialization, provided to a functionally impaired adult. Companions may provide limited assistance or supervise the individual with such tasks as activities of daily living, meal preparation, laundry and shopping, but do not perform these activities as discrete services. The Companion may also perform housekeeping tasks which are incidental to the care and supervision of the individual. Companion Service is provided in accordance with a therapeutic goal as stated in the POC, and is not purely diversional in nature. The therapeutic goal may be related to client safety and/or toward promoting client independence or toward promoting the mental or emotional health of the client.

Companion Service is not an entitlement. It is provided based on the needs of the individual client as reflected in the POC. The objective of Companion Service is to provide support and supervision that is focused on safety, non-medical care and socialization for clients.

Section 10.6.1 - Description of service to be provided are as follows:

1. The unit of service will be 15 minutes of direct Companion Service provided to the client. The number of units per visit must be indicated on the POC and the Service Authorization Form. The maximum number of units that can be authorized may not exceed four (4) hours daily. The amount of time authorized does not include the Companion Worker's transportation time to or from the client's home, or the Companion Worker's break or mealtime.

2. The number of units and service provided to each client is dependent upon the individual client's needs as set forth in the client's POC which is established by the case manager and subject to approval by the Medicaid Agency.

   Medicaid will not reimburse for activities performed which are not within the scope of services defined.

3. Companion Service includes:
   a. Supervision/observation of daily living activities, such as:
      (1) Reminding client to bathe and take care of personal grooming and hygiene;
      (2) Reminding client to take medication;
      (3) Observation/supervision of snack, meal planning and preparation, and/or eating;
      (4) Toileting or maintaining continence.
   b. Accompanying the client to necessary medical appointments, grocery shopping, and obtaining prescription medications. The Companion Worker is not allowed to transport clients, only to accompany them.
   c. Supervision/assistance with laundry.
   d. Performance of housekeeping duties that are essential to the care of the client.
   e. Assist with communication.
   f. Reporting observed changes in the client's physical, mental or emotional condition.
   g. Observing/reporting home safety. The Companion Worker will ensure that the client is residing in a safe environment. Ensuring home safety means the Companion Worker will have a general awareness of the home's surroundings and any concerns with safety issues will be reported to the Companion Worker Supervisor as well as to the case manager for follow up.

The DSP must provide all of the following staff positions through employment or sub contractual arrangements. Companion Worker Qualifications are as follows:

1. All Companion Worker Supervisors will have the following qualifications:
   a. High school diploma or equivalent;
   b. Be able to evaluate Companion Worker in terms of their ability to perform assigned duties and communicate with the individuals;
   c. Be able to assume responsibility for in-service training for Companion Workers by individual instructions, group meetings, or workshops;
   d. Submit to programs for the testing, prevention, and control of tuberculosis annually;
   e. Criminal background check;

f. Have reference which will be verified thoroughly and documented in the personnel file. References must include previous employers and the Nurse Aide Registry;
g. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or case manager's dissatisfaction, complaints or grievances regarding the provision of Companion Service;
h. Possess a valid government issued picture identification, not to include DSP issued identification.

2. All Companions Workers must meet the following qualifications:
   a. Be able to read and write;
   b. Submit to programs for the testing, prevention, and control of tuberculosis annually;
   c. Statewide criminal background check;
   d. Have references which are verified thoroughly by the DSP and documented in the personnel file. References must include previous employers and the Nurse Aide Registry;
   e. Possess a valid, picture identification;
   f. Be able to follow the POC with minimal supervision unless there is a change in the client's condition.
   g. Complete a probationary period determined by the employer with continued employment contingent on completion of the in-service training program.

3. Minimum Training Requirements for Companion Worker are as follows:
   The Companion Worker training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing/or conducting the training. The Companion Worker training program must be approved by the OA. Proof of the training must be recorded in the personnel file.

   The Companion Worker must successfully complete orientation training in areas specified below prior to providing Companion Services or have documentation of personal, volunteer, or paid experience in the care of adults, families, and/or the disabled, home management, household duties, preparation of food, and be able to communicate observations verbally and in writing.
   a. Meal planning and preparation;
   b. Laundry/shopping;
   c. Provision of care and supervision including individual safety;
   d. First aid in emergency situations;
   e. Documentation of services provided per written instructions;
   f. Basic infection Control/Universal Standards; and,
   g. Fire and safety measures;
   h. Assist clients with medications;
   i. Communication skills;
   j. Client rights;
   k. Other areas of training as appropriate or as mandated by the OA.

4. The annual in-service training will be provided by the DSP and is in addition to the training required prior to job placement.

5. All Companion Workers must have at least six (6) hours in-service training annually. For Companion Workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a Companion Worker.

6. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.

7. Topics for specific in-service training may be mandated by Medicaid or the OA.

8. In-service training may entail demonstration of providing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs are limited to four (4) hours annually and must be approved for content and credit hours by the OA, prior to the planned training. The DSP shall submit the proposed program(s) to the OA at least forty-five (45) days prior to the planned implementation.

9. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the six (6) hours required in-service for all Companion Workers each calendar year.

10. The DSP Agency shall maintain records on each employee which shall include the following:
    a. Application for employment;
    b. Job description;
    c. Statewide criminal background check;
    d. References which are verified thoroughly by the DSP and documented in the personnel file;
    e. Record of health (annual tuberculin tests);
    f. Record of pre-employment and in-service training;
    g. Orientation;
    h. Evaluations;
    i. Supervisory visits;
    j. Copy of photo identification;
    k. Reference contacts;
    l. Other forms as required by State and Federal law, including agreements regarding confidentiality.

Section 10.6.2 - Procedures for Service are as follows:

1. The case manager will submit a Service Authorization Form and a copy of the POC to the DSP Agency, authorizing Companion Service and designating the units, frequency, beginning date of service, and types of duties in accordance with the individual client's needs as set forth in the POC.

2. The DSP Agency will initiate Companion Service within three (3) working days of the designated START DATE on the Service Authorization Form in accordance with the following:
    a. Services must **not** be provided prior to the authorized start date as stated on the Service Authorization Form
    b. The DSP Agency will adhere to the services and schedule as authorized by the case manager on the Service Authorization Form. No payment will be made for services unless authorized and listed on the POC.

3. Provision of Service Authorized:
   a. Companion Service cannot be provided at the same time as other authorized waiver services are being provided, except for case management.
   b. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to assure that payment is made to the relatives or friends as providers only in return for companion services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the case management file showing that the family member is a qualified provider and the lack of other qualified providers in remote areas. The case manager will conduct an initial assessment of qualified providers in the area of which the client will be informed. The case manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The case manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for client's living in a remote area.
   c. The Companion Worker is not allowed to provide transportation when he/she is accompanying a client.
   d. Companion Service is only available to those clients who reside alone

4. Companion Workers will maintain a separate service log for each client to document their delivery of services.
   a. The Companion Worker shall complete a service log that will reflect the types of services provided, the number of hours of service, and the date and time of the service.
   b. The service log must be signed upon each visit by the client, or family member/responsible party and the Companion Worker. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Companion Worker must document the reason the log was not signed by the client or family member/responsible party. The family member may designate another person to sign in their absence but it must be documented on the HCBS application.
   c. The service log will be reviewed and signed by the Companion Worker Supervisor at least once every two (2) weeks. Service logs will be retained in the client's file. Any corrections to the log must be clearly noted with a new date and initials of the client or designee.
   d. Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.

5. Monitoring of Service
   a. The Companion Worker Supervisor will visit the home of clients to monitor services.
   (1) The Companion Worker Supervisor will make the initial visit to the client's residence prior to the start of Companion Service for the purpose of reviewing the POC, providing the client written information regarding rights and responsibilities, how to register complaints and discussing the provisions and supervision of the service.

The initial visit should be held at the client's place of residence and should include the Case Manager, the Companion Supervisor, the client and caregiver if feasible. It is advisable to also include the Companion Worker in the initial visit.

(2) The Companion Worker Supervisor will provide on-site supervision at the client's place of residence at a minimum of every 60 days for each client. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the Companion Worker. Supervisory visits must be documented in the individual client record. Client must be present for visit.

The DSP must complete the 60-day supervisory review which includes, at a minimum, assurance that the services are being delivered consistent with the POC and the Service Authorization Form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. A copy of the supervisory visit must be submitted to the case manager within 10 calendar days after the 60-day supervisory review.

In the event the on-site supervisory visit cannot be completed in a timely manner due to the client's being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Companion Service. Documentation regarding this action should be in the DSP client file.

(3) Each Companion Worker supervisory visit will be documented in the client's file. The Companion Worker Supervisor's report of the on-site visits will include, at a minimum:
   (1) Documentation that services are being delivered consistent with the POC;
   (2) Documentation that the client's needs are being met;
   (3) Reference to any complaints which the client or family member/responsible party has lodged and action taken;
   (4) A brief statement regarding any changes in the client's Companion Service needs.
   (5) The Companion Service Supervisor will provide assistance to Companion Worker as necessary.
   (6) Companion Worker Supervisor must be immediately accessible by phone during the time Companion Service is being provided. Any deviation from this requirement must be prior approved in writing by the OA and AMA. If this position becomes vacant, the OA and AMA must be notified in writing within 24 hours if the position becomes vacant.
   (7) The Companion Worker Supervisor must provide direct supervision of each Companion Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the Companion Worker's personnel record.
      - Direct supervision may be carried out in conjunction with an on-site supervisory visit. Client and worker must be present.
   (8) The Companion Worker Supervisor will provide and document the supervision, training, and evaluation of Companion Workers according to the requirements in the approved Waiver Document.

6. Missed Visits, and Attempted Visits
   a. Missed Visits
      (1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

(2) The DSP shall have a written policy assuring that, when a Companion Worker is unavailable, the Companion Worker Supervisor will assess the need for services and makes arrangements for a substitute to provide services as necessary.
Clients who are designated by the case manager as being at-risk should be given first priority when Companion Service visits must be temporarily prioritized and/or reduced by the DSP.
   a) If the Companion Worker Supervisor sends a substitute, the substitute will complete and sign the service log after finishing duties.
   b) If the Companion Worker Supervisor does not send a substitute, the Companion Worker Supervisor will contact the client and inform them of the unavailability of the Companion Worker.

(3) The DSP will document missed visits in the client's files.

(4) Whenever the DSP determines that services cannot be provided to an at-risk client as authorized, the case manager must be notified by telephone immediately. All missed/attempted visits for one week and the reason for the missed/attempted visit must be reported in writing on the "**Weekly Missed/ Attempted Visit Report**" form to the case manager on Monday of each week. Any exception to the use of this form must be approved by the OA and AMA.

(5) The DSP may **not** bill for missed visits.

b. Attempted Visits

(1) An attempted visit occurs when the Companion Worker arrives at the home and is unable to provide services because the client is not at home or refuses services.

(2) If an attempted visit occurs:
   a) The DSP may **not** bill for the attempted visits.
   b) The Companion Worker Supervisor will contact the client to determine the reason why the client was not present or why services were refused, and document in the client's file.
   c) The DSP will notify the case manager promptly whenever an attempted visit occurs and will notify the CM within one (1) working day after the second attempted visit whenever two attempted visits occur within the SAME week.

7. Changes in Services

a. The DSP will notify the case manager within one (1) working day of the following changes:
   - Client's condition and/or circumstances have changed and that the POC no longer meets the client's needs;
   - Client does not appear to need Companion Service;
   - Client dies or moves out of the service area;
   - Client indicates Companion Service is not wanted; and,
   - Client loses Medicaid financial eligibility;
   - When services can no longer be provided.

b. The case manager will notify the DSP within one (1) working day if a client becomes ineligible for waiver services.

c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the POC, the DSP shall contact the case manager to discuss having these duties added.

(1) The case manager will review the DSP's request to modify services and respond within one (1) working day of the request.

(2) The case manager will approve any modification of duties to be performed by the Companion and re-issue the Service Authorization Form accordingly.
(3) Documentation of any changes in a POC will be maintained in the client's file.
   a) If the total number of hours of service is changed, a new Service Authorization Form is required from the case manager.
   b) If the types or times of services are changed, a new Service Authorization Form is required from the case manager.
   c) If an individual declines Companion Service or has become ineligible for services, a Service Authorization Form for termination is required from the case manager.

8. Documentation and Record-Keeping
   a. The DSP shall maintain a record keeping system for each client that documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available upon request to Medicaid, the OAs, or other agencies contractually required to review information.
   The DSP shall maintain a file on each client, which shall include the following:
   (1) A current HCBS application;
   (2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Companion visits for the client;
   (3) Documentation of client-specific assistance and/or training rendered by the supervisor to a Companion Worker;
   (4) All service logs;
   (5) Records of all missed or attempted visits;
   (6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken; and,
   (7) Evaluations from all 60 day on-site supervisory visits to the client;
   (8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;
   (9) Initial visit for in-home services;
   (10)Any other notification to case manager;
   (11)Permission statements to release confidential information, as applicable.
   b. The DSP will retain a client's file for at least five (5) years after services are terminated.
   c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

Section 10.6.3 - Rights, Responsibilities, and Service Complaints are as follows:

1. The OA has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Companion Service provided and will provide information about how to register a complaint with the case manager as well as AMA.
   a. Complaints which are made against Companion Workers will be investigated by the DSP and documented in the client's file.
   b. All complaints to be investigated will be referred to the Companion Worker Supervisor who will take appropriate action.

c. The Companion Worker Supervisor will take any action necessary and document the action taken in the client's and/or the employee's files, whichever is most appropriate based on the nature of the complaint.
d. The Companion Worker Supervisor will contact the case manager by letter or telephone about any complaint and any corrective action taken.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

Section 10.6.4 - Administrative Requirements are as follows:
In addition to all conditions and requirements contained in the Scope of Service as well as in the contract with the OA, the DSP shall be required to adhere to the following stipulations:

1. The DSP shall designate an individual to serve as the administrator who shall employ qualified personnel and ensure adequate staff education, in-service training, and perform employee evaluations. This does not have to be a full-time position; however, the designated administrator will have the authority and responsibility for the direction of Companion Service for the DSP Agency. The DSP Agency shall notify the OA and AMA within three (3) working days in the event of a change in the administrator, address, telephone number, or of an extended absence of the agency administrator.

2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This shall be readily accessible to all staff. A copy of this information shall be forwarded to AMA and the OA at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to AMA and the OA.

3. Administrative and supervisory functions shall not be delegated to another organization.

4. A list of the members of the DSP's governing body shall be available to the OA and AMA upon request.

5. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the OA contract and the waiver document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

6. During the life of this contract, the DSP shall acquire and maintain liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the DSP. Upon request, the DSP shall furnish a copy of the insurance policy to the OA and AMA.

7. The DSP shall conform to applicable federal, state and local health and safety rules and regulations, and have an on-going program to prevent the spread of infectious diseases among its employee (such as making substitutions for ill Companion Workers and training Companion Workers in personal hygiene and proper food handling and storage).

8. The DSP shall maintain an office which will be open during normal business hours and staffed with qualified personnel.

9. The DSP shall provide its regularly scheduled holidays to the OA. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will assure that the service is rendered.

10. The DSP Agency must maintain an annual operating budget which shall be made available to the OA and/or AMA upon request.

Section 10.6.5 - The Provider Experience is as follows:
Providers of Companion Service must meet all provider qualifications prior to rendering the Companion Service.

All personnel with direct client contact or access to client information must have complete reference verification and statewide criminal background checks on file prior to client contact or client access.

Section 10.7: Homemaker

A. Definition

Homemaker Service provides assistance with general household activities such as meal preparation and routine housecleaning and tasks, such as, changing bed linens, doing laundry, dusting, vacuuming, mopping, sweeping, cleaning kitchen appliances and counters, removing trash, cleaning bathrooms, and washing dishes. This service may also include assistance with such activities as obtaining groceries and prescription medications, paying bills, and writing and mailing.

Homemaker Services is not an entitlement. It is based on the needs of individual client as reflected in the POC.

B. Objective

The objective of Homemaker Services (HM) is to preserve a safe and sanitary home environment, assist clients with home care management duties, to supplement and not replace care provided to clients, and to provide needed observation of clients participating in the Elderly/Disabled waiver.

C. Description of Service to be Provided

1. The unit of service is 15 minutes of direct Homemaker Service provided in the client's residence (except when shopping, laundry services, etc. must be done off-site). The amount of time authorized does not include the Homemaker's transportation time to or from the client's residence, or the Homemaker's break or mealtime.

2. The number of units and services provided to each client is dependent upon the individual client's needs as set forth in the POC.

Medicaid will not reimburse for activities performed which are not within the scope of services.

3. No payment will be made for services that are not listed on the POC and the Service Authorization Form.

4. Homemaker Services duties include, but are not limited to, the following:
   a. Meal or snack preparation, meal serving, cleaning up afterwards;
   b. General housekeeping includes cleaning (such as sweeping, vacuuming, mopping, dusting, taking out trash, changing bed linens, defrosting and cleaning the refrigerator, cleaning the stove or oven, cleaning bathrooms); laundry (washing clothes and linen, ironing, minor mending); and, other activities as needed to maintain the client in a safe and sanitary environment;
   c. Essential shopping for food and other essential household or personal supplies which may be purchased during the same trip, and picking up prescribed medication;
   d. Assistance with paying bills (which includes opening bills, writing checks but not signing them) and delivering payments to designated recipients on behalf of the client;
   e. Assistance with communication which includes placing phone within client's reach and physically assisting client with use of the phone, orientation to daily events, paying bills, and writing letters;
   f. Observing and reporting on client's condition;
   g. The homemaker is not allowed to transport the client by vehicle in the performance of their task;
   h. Reminding clients to take medication
   i. Observing and reporting on home safety. The Homemaker service worker will insure that the client is residing in a safe environment. Ensuring home safety means that the worker will have a general awareness of the home's surroundings and any concerns with safety issues will be reported to the Homemaker Supervisor as well as the case manager for follow up.

   Note: Under no circumstances should any type of skilled medical or nursing service be performed by a Homemaker.

5. The DSP is not responsible for providing funds, supplies, or groceries to perform Homemaker Services.

D. Staffing

The DSP must provide all of the following staff positions through employment and/or sub contractual arrangements.

1. All Homemaker Supervisors will have the following qualifications:
   a. High school diploma or equivalent;
   b. Be able to evaluate homemakers in terms of their ability to perform assigned duties and relate to the client;
   c. Have the ability to coordinate or provide orientation and in-service training to Homemaker Workers on either an individual basis or in a group setting;
   d. Submit to a program for the testing, prevention, and control of tuberculosis annually;
   e. Must have references which will be verified thoroughly and documented in the DSP

personnel file. References must include statewide criminal background checks (including sex offender registry), previous employers, and the Nurse Aide Registry (if applicable);

f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or case manager's dissatisfaction, complaints or grievances regarding the provision of Homemaker service;
g. Have the ability to evaluate the Homemaker Worker (HM Worker) in terms of his/her ability to carry out assigned duties and relate to the client;
h. Possess a valid, picture identification.

2. All individuals providing Homemaker Service must meet the following qualifications:
   a. Be able to read and write;
   b. Submit to a program for the testing, prevention, and control of tuberculosis annually;
   c. Have references which will be verified thoroughly and documented in the DSP personnel file. References must include statewide background checks (including sex offender registry), previous employers, and the Nurse Aide Registry (if applicable);
   d. Be able to work independently on an established schedule;
   e. Possess a valid, picture identification;
   f. Be able to follow the POC with minimal supervision;
   g. Complete a probationary period determined by the employer with continued employment contingent on completion of a Homemaker in-service training program.
3. Minimum Training Requirements for Homemakers:
   The Homemaker training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing and/or conducting the training. The Homemaker training program must be approved by the OA. Proof of the training must be recorded in the personnel file.

   The annual in-service training is in addition to the training required prior to the provision of care. All Homemakers must have at least six (6) hours, in-service training annually from the following areas:
   a. Maintaining a safe and clean environment;
   b. Providing care including individual safety, laundry, serve and prepare meals, and household management;
   c. First aid in emergency situations;
   d. Fire and safety measures;
   e. Client rights;
   f. Record keeping; such as,
      - A service log signed by the client or family member/ responsible person and Homemaker Worker to document what services were provided for the client in relation to the POC.
      - Submitting a written summary to the Homemaker Worker Supervisor of any problems with client, client's home or family. The Supervisor in return should notify the case manager.
   g. Communication skills;
   h. Basic infection control/Universal Standards;
   i. Other areas of training as appropriate or as mandated by the OA.

4. The DSP will be responsible for providing a minimum of six (6) hours of relevant in-service training per calendar year for each Homemaker Worker. In-service training is in addition to Homemaker Worker orientation training. For Homemaker Workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a Homemaker Worker.
5. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.
6. Topics for specific in-service training may be mandated by Medicaid or the OA.
7. In-service training may entail demonstration of maintaining a safe and clean environment for the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs are limited to four (4) hours annually and must be approved for content and credit hours by Medicaid and the OA, prior to the planned training. The DSP shall submit proposed program(s) to the OA at least 45 days prior to the planned implementation.
8. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the six (6) hours required in-service for all Homemaker Workers each calendar year.
9. The DSP Agency shall maintain records on each employee, which shall include the following:
    a. Application for employment;
    b. Job description;
    c. Statewide criminal background checks and references;
    d. Record of health with annual tuberculin tests (this includes <u>any</u> staff member that has direct client contact);
    e. Record of pre-employment and in-service training;
    f. Orientation;
    g. Evaluations;
    h. Supervisory visits;
    i. Copy of photo identification;
    j. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;
    k. Reference contacts;
    l. Other forms as required by state and federal law, including agreements regarding confidentiality.

E. Procedures for Service

1. The case manager will submit a Service Authorization Form and POC to the DSP Agency authorizing Homemaker Service and designating the units, frequency, beginning date of service, and types of duties in accordance with the individual client's needs.
2. The DSP Agency will initiate Homemaker Service within three (3) working days of the designated START DATE on the Service Authorization Form in accordance with the following:
    a. Services must not be provided prior to the authorized start date as stated on the Service Authorization Form.
    b. The DSP Agency will adhere to the services and schedule as authorized by the case manager on the Service Authorization Form. No payment will be made for services unless authorized.
3. The DSP Agency may recommend to the case manager any changes in the hours, times, or specified duties requested. The case manager will review a client's POC within one (1) working day of the DSP's request to modify the POC. A change in the Service

Authorization Form will be submitted to the DSP Agency if the case manager concurs with the request.

4. Homemakers will maintain a separate service log to document their delivery of services.
   a. The Homemaker shall complete a service log daily. The service log will reflect the types of services provided, the number of hours of service, and the times of service.
   b. The service log must be signed upon each visit by the client, or family member/responsible party and the Homemaker Worker. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Homemaker must document the reason the log was not signed by the client or family member/responsible party.
   c. The service log will be reviewed and signed by the Homemaker Supervisor at least once every two (2) weeks. Service logs will be retained in the client's file.
   d. Client visits may be recorded electronically via telephony. Electronic documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone. These electronic records may be utilized in place of client signatures.
5. Provision of Service Authorized:
   a. Homemaker Service cannot be provided at the same time as other authorized waiver services are being provided, except for case management.
   b. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to ensure that payment is made to the relatives or friends as providers only in return for homemaker services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the case management file showing that the family member is a qualified provider and the lack of other qualified providers in remote areas. The case manager will conduct an initial assessment of qualified providers in the area of which the client will be informed. The case manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The case manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for client's living in a remote area.
6. Monitoring of Service:
   Homemaker Service must be provided under the supervision of the individual who meets the qualifications in D.1. and will:
   a. Make the initial visit prior to the start of Homemaker Service for the purpose of reviewing the POC, providing the client written information regarding rights and responsibilities and how to register complaints, and discussing the provision and supervision of the service(s).
      The initial visit should be held at the client's place of residence and should include the case manager, the Homemaker Supervisor, the client and caregiver if feasible. It is advisable to also include the Homemaker Worker in the initial visit.
   b. Be immediately accessible by phone during the time Homemaker Service is being provided.

Any deviation from this requirement must be prior approved in writing by the OA and AMA. If this position becomes vacant the OA and AMA must be notified within 24 hours.

c. Provide and document supervision of, training for, and evaluation of Homemaker Workers according to the requirements in the approved waiver document.
d. Provide on-site (client's residence) supervision of at a minimum of every 60 days for each client. Supervisory visits must be documented in the individual client record. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the Homemaker Worker. In the event the on-site supervisory visit cannot be completed in a timely manner due to the client's being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Homemaker Service. Documentation regarding this action should be in the DSP client record. Client must be present for visit.
e. The DSP must complete the 60-day supervisory review which includes, at a minimum, assurance that the services are being delivered consistent with the POC and the Service Authorization Form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. A copy of the supervisory visit must be submitted to the case manager within 10 calendar days after the 60-day supervisory review.
f. Assist Homemaker Workers as necessary as they provide individual Homemaker Service as outlined in the POC. Any supervision/assistance given must be documented in the individual client's record.
g. The Homemaker Supervisor must provide direct supervision of each Homemaker Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the Homemaker Worker's personnel record.
    - Direct supervision may be carried out in conjunction with an on-site supervisory visit.
    - Client and worker must be present.

    The Homemaker Supervisor will provide and document the supervision, training, and evaluation of Homemaker Workers according to the requirements in the approved Waiver Document.

7. Missed Visits and Attempted Visits
    a. Missed Visits
        (1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.
        (2) The DSP shall have a written policy assuring that when a Homemaker Worker is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary.
    b. Clients who are designated by the case managers being at-risk should be given first priority when Homemaker Service visits must be temporarily prioritized and/or reduced by the DSP.
        (1) If the Supervisor sends a substitute, the substitute will complete and sign the daily log after finishing duties. If a substitute Homemaker Worker was offered to the client/caregiver, but refused, this should be documented in the DSP client record on the "Weekly Missed/Attempted Visit Report."
        (2) If the Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Homemaker Worker.

(3) The DSP will document missed visits in the client's files.
(4) Whenever the DSP determines that services cannot be provided to an at-risk client as authorized, the case manager must be notified by telephone immediately. All missed/attempted visits for one week and the reason for the missed/attempted visit must be reported in writing on the "Weekly Missed/ Attempted Visit Report" form to the case manager on Monday of each week. Any exception to the use of this form must be approved by the OA and AMA.
(5) The DSP may not bill for missed visits.

c. Attempted Visits
(1) An attempted visit occurs when the Homemaker Worker arrives at the home and is unable to provide services because the client is not at home or refuses services.
(2) If an attempted visit occurs:
(a) The DSP may not bill for the attempted visits.
(b) The Supervisor will contact the client or family member to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.
(c) The DSP will notify the case manager within one (1) working day after the second attempted visit whenever two (2) attempted visits occur within the SAME week.

8. Changes in Services
a. The DSP will notify the case manager within one (1) working day of the following changes:
(1) Client's condition and/or circumstances have changed and the POC no longer meets the client's needs:
(2) Client does not appear to need Homemaker Service;
(3) Client dies or moves out of the service area;
(4) Client indicates Homemaker Service is not wanted;
(5) Client loses Medicaid financial eligibility;
(6) When services can no longer be provided.
b. The case manager will notify the DSP immediately if a client becomes medically or financially ineligible for waiver services.
c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the POC, the DSP shall contact the case manager to discuss having these duties added.
(1) The case manager will review the DSP's request to modify services and respond within one (1) working day of the request.
(2) The case manager will approve any modification of duties to be performed by the HMW and re-issue the Service Authorization Form accordingly, if he/she concurs with the request.
(3) Documentation of any change in the POC or Service Authorization Form will be maintained in the client's file.
a) If the total number of hours or types of services are changed, a new Service Authorization Form is required from the case manager.
b) If an individual declines Homemaker Service or has become ineligible for services, a Service Authorization Form for termination is required from the case manager.

9. Documentation and Record-Keeping
a. The DSP shall maintain a record keeping system for each client that documents the

units of service delivered based on the Service Authorization Form. The client's file shall be made available to Medicaid, the OAs, or other agencies contractually required to review information upon request.

b. The DSP shall maintain a file on each client, which shall include the following:
   (1) A current HCBS application;
   (2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Homemaker visits for the client;
   (3) Documentation of client specific assistance and/or training rendered by the Supervisor to a Homemaker Worker;
   (4) All service logs;
      (a) The service log must be reviewed and initialed by the Homemaker Supervisor at least once every two (2) weeks.
   (5) Records of all missed or attempted visits;
   (6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken; and,
   (7) Evaluations from all 60 day on-site supervisory visits to the client;
   (8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;
   (9) Initial visit for in-home services;
   (10) Any other notification to case manager;
   (11) Permission statements to release confidential information, as applicable.

c. The DSP will retain a client's file for at least five (5) years after services are terminated.

d. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The OA has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.
2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Homemaker Service provided and will provide information about how to register a complaint with the case manager as well as AMA.
   a. Complaints which are made against the HMW will be investigated by the DSP Agency and documented in the client's file.
   b. All complaints which are to be investigated will be referred to the HMW Supervisor who will take appropriate action.
   c. The HMW Supervisor will take any action necessary and document the action taken in the client's and/or the employee's files, whichever is most appropriate based on the nature of the complaint.
   d. The HMW Supervisor will contact the case manager by letter or telephone about any complaint and any corrective action taken.
3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the OA within three (3) working days of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.
2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the OA at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and the OA.
3. Administrative and supervisory functions shall not be delegated to another agency or organization.
4. A list of the members of the DSP's governing body shall be made available to the OA and/or AMA upon request.
5. The DSP Agency must maintain an annual operating budget which shall be made available to the OA and/or AMA upon request.
6. During the life of the contract the DSP Agency shall acquire and maintain liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the OA and/or AMA.
7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the OA and/or its agents.
8. The DSP Agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.
9. The DSP shall provide its regularly scheduled holidays to the OA. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.
10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the OA contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

H. Provider Experience

Providers of Homemaker Service must meet all provider qualifications prior to rendering the Homemaker Service.

All personnel with direct client contact or access to client information must have complete reference verification and statewide criminal background checks on file prior to client contact or access to client information.

Section 10.8: Home Modification

Service Definition (Scope)

Those physical adaptations to the home, required by the participant's POC, which are necessary to ensure the health, welfare and safety of the participants, or which enables the participants to function with greater independence in the home and without which, the participant would require institutionalization. Such adaptations may include the installation of ramps and grab-bars and/or the widening of doorways in order to accommodate the medical equipment and supplies which are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver participant, such as floor covering, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home, any type of construction affecting the structural integrity of the home, changes to the existing electrical components of the home, or permanent adaptations to rental property are also excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

A. Objective:

The objective of Environmental Accessibility Adaptations Services (EAA) is to ensure the health, welfare and safety of waiver participants which enables them to function with greater independence in their current living arrangements.

B. Provider Qualifications:

EAA will be provided by entities capable of constructing or installing the needed apparatus. Any construction/installation completed must be in accordance with state and local building code requirements, American with Disabilities Act Accessibility Guidelines (ADAAG) and done by a licensed contractor.

C. Description of Services to Be Provided:

1. The ACT Waiver program will pay for this service when items requested are not covered under the regular State Plan program and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. The OA medical record on each participant must substantiate the need for services, must include all findings and information supporting medical necessity, and must detail all treatment provided.
2. The adaptations shall not include any improvements to the home which are not of direct medical or remedial benefit to the client, such as floor covering, roof repair, central air conditioning, etc.
3. All services shall be provided in accordance with applicable state or local building codes, and ADAAG regulations. This service will be provided by a licensed contractor.

D. Conduct of Service

1. This service will be authorized by the ACT Waiver case manager. The case manager should consult with a Rehabilitation Technology Specialist (RTS) to assist when there is questionable doubt as to the construction of EAA. RTS may also be utilized in developing specifications and in obtaining final approval of completed modification adaptations. The case manager must make sure that all the requirements are met.
2. Environmental Accessibility Adaptations must be prior authorized and approved by Alabama Medicaid, or its designee, and must be listed on the participant's POC. The maximum amount for this service is $5,000 per waiver recipient for the entire stay on the waiver. Any

expenditure in excess of $5,000 must be approved by the state coordinator and the Medicaid designated personnel.

3. A PRESCRIPTION IS NOT REQUIRED FOR THIS SERVICE.
4. If the participant is not pleased with the service, the contractor is required to make adjustments as long as the complaints are within reason.

This service is necessary to assist an individual to transition from an institutional level of care to the home and community based waiver. Limits on EAA are $5,000 per waiver participant for the entire stay on the waiver. Any expenditure in excess of $5,000 must be approved by the ACT Waiver Coordinator and the Medicaid Agency designated personnel. The service should not be billed until the first day the participant is transitioned and has begun to receive waiver services in order to qualify as waiver funds. If the individual fails to transition to the ACT Waiver, reimbursement will be at the administrative rate.

Service Delivery Method: Provider managed
Provider Type: Licensed Contractor
Provider Qualifications
License *(specify): Any construction/installation completed must be in accordance with state and local building code requirements, American with Disabilities Act Accessibility Guidelines (ADAAG) and done by a licensed contractor.*

Verification of Provider Qualifications
Entity Responsible for Verification: OA and Rehabilitation Technology Specialist
Frequency of Verification: Prior to contract approval, annually for approved providers based on meeting previous requirements, or more often if needed based on service monitoring concerns.

Section 10.9: Home Delivered Meals

Home Delivered meals are provided to an individual who is unable to meet his/her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of home delivered meals. (The individual must be age 21 or older to receive this service on the E&D waiver.)

This service will provide at least one (1) nutritionally sound meal per day to adults unable to care for their nutritional needs because of a functional disability dependency, who require nutritional assistance to remain in the community and do not have a caregiver available to prepare a meal for them. Meals provided by this service will not constitute a full daily nutritional regimen.

This service will be provided as specified in the POC, which may include: seven (7) or fourteen (14) frozen meals per week. In addition to frozen meals, the service may include the provisions of two (2) or more shelf-stable meals (not to exceed six meals per six-month period) to meet emergency nutritional needs when authorized in the recipient's care plan.
In the event of an expected storm or disaster, the Meals Coordinator will authorize an approved Disaster Meal Service Plan.

A unit is defined as:
Seven-(7) pack of frozen meals equal to 1 unit.
Two (2) shelf-stable meals equal to 1 unit.

Seven-(7) pack of breakfast meals equal to 1 unit.

Section 10.10: Medical Supplies

Service Definition (Scope)

Medical supplies include devices, controls and/or appliances, specified in the POC, which enable waiver participants to increase their ability to perform activities of daily living, to maintain health and safety in the home environment, and to perceive, control, or communicate with the environment in which they live. All waiver medical supplies must be prescribed by a physician, be medically necessary and be specified in the POC.

A. Objective:

The objective of the Medical supplies service is to maintain the participant's health, safety and welfare and to prevent further deterioration of a condition such as decubitus ulcers. This service is necessary to prevent institutionalization. Medical supplies ensure health and safety for the duration of usefulness of supplies. Medical supplies are necessary for the care and functional capabilities of the recipient in the home.

B. Provider Experience

Providers of this service will be those who have a signed provider agreement with AMA, and ADSS. The case manager must provide the participant with a choice of vendors in the local area of convenience.

C. Description of Services to be provided

1. Medicaid will pay for a service when the service is covered under the ACT Waiver and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. The OA records on each participant must substantiate the need for services, must include all findings and information supporting medical necessity, and must detail all treatment provided.
2. Medical supplies are necessary to maintain the participant's health, safety and welfare and to prevent further deterioration of a condition such as decubitus ulcers. This service is necessary to prevent institutionalization.
3. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-Tips, etc.
4. Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the participant.
5. All items shall meet applicable standards of manufacture, design and installation.

Supplies are limited to $1800.00 per recipient per year. Providers must maintain documentation of items purchased for recipient which is specific to the recipients.

D. Conduct of Service

1. This service will only be provided when authorized by the participant's physician.
2. Providers of this service will be those who have a signed provider agreement with AMA, and the Department of Rehabilitation Services.
3. Supplies must be indicated on the participant's POC, they must be medically necessary to maintain the participant's ability to remain in the home and live independently.
4. Reimbursement for medical supplies shall be limited to $1800.00 annually per participant. Receipt for all supplies purchased must be kept in the participant's case record.

5. The case manager must provide the participant with a choice of vendors in the area. A signed Participant Choice of Vendor form should be placed in the case file and a copy provided to the participant. Services should not be denied due to an absence of the signature of the waiver participant/representative.
6. Any supplies that are covered under the State DME program cannot be billed as a waiver item. It must be billed through the State DME procedure codes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
All waiver medical supplies must be prescribed by a physician, be medically necessary and be specified in the POC. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-tips, etc. Items reimbursed with waiver funds shall be in addition to any medical supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. Medical supplies are limited to $1800.00 per recipient per year. The OA must maintain documentation of items purchased for recipient.
Service Delivery Method Provider managed
Provider Qualifications
License: *Business License*
Other Standard Providers of this service will be those who have signed provider agreements with AMA and the OA. The case manager must provide the participant with a choice of vendors in the local area of convenience.
Verification of Provider Qualifications
Entity Responsible for Verification: OA Certification Surveyor
Frequency of Verification: Prior to contract approval, annually for approved providers based on previous score, or more often if needed based on service monitoring concerns.

Section 10.11: Personal Assistant

Service Definition *(Scope):*
PAS are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities on the job. These activities would be performed by the individual if that individual did not have a disability. Such services shall be designed to increase the individual's independence and ability to perform every day activities on the job. This service will support that population of individuals with physical disabilities who need services beyond personal care and primarily those in competitive employment either in their home or in an integrated work setting. An integrated work setting is defined as a setting typically found in the community which employs individuals with disabilities and there is interaction with non-disabled individuals who are in the same employment setting. This service will be sufficient to support the competitive employment of people with disabilities of at least 40 hours per month. The service will also be sufficient in amount, duration, and scope so that an individual with a moderate to severe level of disability would be able to obtain the support needed maintain employment.

A. **Objective:**
The objective of PAS is to provide a range of services designed to assist an individual with physical disabilities to perform activities on the job.

B. **Provider Experience**
Agencies desiring to be a provider must have demonstrated to the OA experience in providing PAS or a similar service.

C. Description of Services to Be Provided

1. This service will be provided to individuals with disabilities inside and outside of their home. It may enable them to maintain employment. The amount of time should be the number of hours sufficient to accommodate individuals with disabilities to work.
2. The unit of service will be per 15 minute increments of direct PAS provided to the recipient. The amount of time authorized does not include the Personal Assistant's transportation time to or from the recipient's home or place of employment.
3. The PAS received by an individual will be based on the individual's needs. The number of hours must be stipulated on the POC and Service Provider Contract.
4. IF THIS SERVICE IS USED FOR EMPLOYMENT, THE OA IS REQUIRED TO HAVE A SIGNED AGREEMENT WITH THE EMPLOYER STATING THAT IT IS ACCEPTABLE TO HAVE A PAS WORKER ON THE JOB-SITE.
5. PAS is required, but are not limited to assisting with:
   Outside Home/Job Site: Essential shopping, transportation to and from work, eating, toileting, medication monitoring, entering or exiting doors. PAS services must be provided under the supervision of the registered nurse who meets the PAS staffing requirements and will:
   a. Make visits to client's residence after the initial visit by the registered nurse.
   b. Be immediately accessible by phone during the hours services are being provided. Any deviation from this requirement must be prior approved in writing by the OA and AMA. If this position becomes vacant the OA must be notified within 24 hours.
   c. Provide and document supervision of, training for, and evaluation of PAS workers according to requirements in the approved waiver document.
   d. Provide on-site (clients' place of residence) supervision of the PAS worker at a minimum of every 60 days for each client. Supervisory visits must be documented in the individual client record and reported to the OA. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances of the PAS worker.
   e. Observe each PAS worker with at least one assigned client at a minimum of every 6 months or more frequently if warranted by substandard performance. This function may be carried out in conjunction with the 60 day supervisory visits, or at another time. Documentation of direct supervisory visits must be maintained in the employee personnel file.
   f. Assist PAS workers as necessary to provide individual PAS as outlined by the POC. Any supervision/ assistance given must be documented in the individual client's record.
4. Minimum training requirements must be completed prior to working with a client. The DSP is responsible for providing/or conducting the training. Proof of training must be recorded in the personnel file. The PAS training program should stress physical, emotional and developmental needs and ways to work with the population served, including the need for respect of the client, his/her privacy, workplace and property.
   NOTE: The PAS training program must be approved by the OA. Minimum training requirements must include the following areas:
   a. Monitor the client, e.g., observe for signs of change in condition, prompt client to take medications as directed, basic recognition of medical problems and medical emergency, basic first aid for emergencies.
   b. Recordkeeping, e.g., a daily log signed by the client or family member/ responsible person and PAS Worker to document what services were provided for the client in relation to the POC and signed at least once every two weeks by the supervising nurse.

c. Basic Infection Control
d. Communication skills
e. The DSP is responsible for providing a minimum of 12 hours relevant in-service training per calendar year. (The annual in-service training requirements can be done on a prorated basis.) Documentation shall include topic, name and title of trainer, training objectives, outline of content, length of training, list of trainees, location, and outcome of training. Topics for specific in-service training may be mandated by Medicaid or the OA. In-service training may entail furnishing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs must be approved for content and credit hours by Medicaid, and/or the OA, prior to being offered and may not exceed 4 of the 12 in-service annual training hours. The DSP shall submit proposed program(s) to the OA at least 45 days prior to the planned implementation. Note: In-service training is in addition to the required training prior to delivery of personal care.

5. Personnel files:
Individual records will be maintained to document that each member of the staff has met the above requirements.

D. Conduct of Service

An individual client record must be maintained by the DSP. Requirements under this section (E) must be documented in each individual client record.

1. The DSP will initiate PAS within three working days of receiving the written contract for services from the case manager. Services must not be provided prior to the authorized start date stated on the Provider Contract.
2. The DSP will notify the case manager within three working days of the following client changes:
   a. Client's condition has changed and the POC no longer meets client needs or client no longer appears to need PAS.
   b. Client dies or moves out of service area.
   c. Client no longer wishes to participate in PAS.
   d. Knowledge of client's Medicaid ineligibility or potential ineligibility.
   e. Client becomes unemployed.
3. The DSP will maintain a recordkeeping system which establishes a client profile in support of units of PAS delivered, based on the Service Provider Contract. The DSP will arrange a daily log reflecting the personal assistance services provided by the PAS worker for the client and the time expended for this service. The daily log must be initialed daily and signed weekly by the client, or employer/family member/responsible person if the client is unable to sign.
4. The DSP must complete the 60-day supervisory review which includes at a minimum assurance that the services are being delivered consistent with the POC and the service contract form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. The summary must be submitted to the case manager within ten (10) calendar days after the 60-day supervisory review.
5. The DSP must have an effective back-up service provision plan in place to ensure that the client receives PAS as authorized.
6. Whenever two consecutive attempted visits occur, the case manager must be notified immediately.

7. The DSP will develop and maintain a Policy and Procedure Manual subject to approval by the OA which describes how activities will be performed in accordance with the terms of the contract and which includes the agency's emergency plan.
8. The DSP will inform clients of their right to complain about the quality of PAS provided and will provide clients with information about how to register a complaint.
9. The Nurse Supervisor must make the initial visit to the client's residence prior to the start of PAS to review the POC and in order to give the client written information. POC must be developed and the service contract form submitted prior to the provision of PAS. The DSP must maintain documentation.
10. The case manager will authorize PAS by designating the amount, frequency and duration of service for clients in accordance with the client's POC which is developed in consultation with the client and others involved in the client's care. The DSP must adhere to those duties which are specified in the POC and the Service Provider Contract. If the DSP identified PAS duties that would be beneficial to the client's care but are not specified in the POC and the Service Provider Contract, the DSP must contact the case manager.
11. The case manager will review a client's POC within three working days of the receipt of the DSP's request to modify the POC.
12. The case manager will notify the DSP immediately if a client becomes medically ineligible for waiver services and issue a service contract form terminating services. The case manager must verify Medicaid eligibility monthly.
13. Under no circumstance should any type of skilled medical service be performed by a PAS worker.
14. No payment will be made for services not listed on the POC and Service Provider Contract.
15. The DSP will retain a client's file for at least five years after services are terminated.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount of time should be the number of hours sufficient to accommodate individuals with disabilities to work. The unit of service will be per 15 minute increments of direct PAS provided to the recipient. The amount of time authorized does not include the Personal Assistant's transportation time to or from the recipient's home or place of employment.
Provider Type:
Home Care Agency or Home Health Agency
Provider Qualifications
License *(specify):*
Business
Certificate *(specify):*
Certificate of Need (CON) if the provider type is a Home Health Agency
Other Standard *(specify):*
Waiver of Certificate of Need approved by the Medicaid Commissioner
Verification of Provider Qualifications /Entity Responsible for Verification:
Alabama Department of Senior Services Certification Surveyor
Frequency of Verification:
Annually upon initial approval and biannually thereafter if no compliance concerns exist.

Section 10.12: Personal Care

Personal Care Service provides assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair, ambulation, maintaining continence and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (IADLs) such as meal

preparation, using the telephone, and household chores such as, laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family.

Personal Care Service is not an entitlement. It is based on the needs of the individual client as reflected in the POC.

Section 10.12.1 - *Objective*

The objective of the Personal Care (PC) Service is to restore, maintain, and promote the health status of clients through home support, health observation, and support of and assistance with activities of daily living.

Personal Care Service is to help waiver clients perform everyday activities when they have a physical, mental, or cognitive impairment that prevents them from carrying out those activities independently.

Section 10.12.2 - *Description of Service to be Provided*

1. The unit of service will be 15 minutes of direct PC Service provided in the client's residence. The number of units authorized per visit must be stipulated on the POC and the Service Authorization Form. The amount of time authorized does not include transportation time to and from the client's residence or the Personal Care Worker's break or mealtime.
2. The number of units and service provided to each client is dependent upon the individual client's needs as set forth in the client's POC established by the case manager. Medicaid will not reimburse for activities performed which are not within the scope of service.
3. PC Service duties include:
   a. Support for activities of daily living, such as:
      - bathing
      - personal grooming
      - personal hygiene
      - meal preparation
      - assisting clients in and out of bed
      - assisting with ambulation
      - toileting and/or activities to maintain continence

   b. Home support that is essential to the health and welfare of the recipient, such as,
      - cleaning
      - laundry
      - home safety

      Home safety includes a general awareness of the home's surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the PCW Supervisor as well as the case manager for follow-up.
   c. Reporting observed changes in the client's physical, mental or emotional condition.
   d. Reminding clients to take medication.

Note: Under no circumstances should any type of skilled medical or nursing service be performed by the PCW.

Section 10.12.3 - *Staffing*

The DSP must provide all of the following staff positions through employment or subcontractual arrangements. PC Supervisors and PC Workers must be qualified, trained, and employed by a Medicare/Medicaid certified Home Health Agency or other health care agencies approved by the Commissioner of AMA.

1. Personal Care (P/C) Supervisors must be a licensed nurse(s) who meet the following requirements:
   a. Have references which will be verified thoroughly and documented in the DSP personnel file. References must include statewide criminal background checks, previous employers and the Nurse Aide Registry.
   b. Be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is currently licensed by the Alabama State Board of Nursing to practice nursing.
   c. Have at least two (2) years' experience as an RN or LPN
   d. Have the ability to evaluate the Personal Care Worker (PC Worker) in terms of his/her ability to carry out assigned duties and to relate to the client.
   e. Have the ability to coordinate or provide orientation and in-service training to PC Workers on either an individual basis or in a group setting.
   f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or case manager's dissatisfaction, complaints or grievances regarding the provision of PC Service.
   g. Submit to a program for the testing, prevention, and control of Tuberculosis annually.
   h. Possess a valid, picture identification.
2. PCWs must meet the following qualifications:
   a. Have references which will be verified thoroughly and documented in the DSP personnel file. References must include statewide background checks, previous employers, sex offender registry, and the Nurse Aide Registry (if applicable).
   b. Be able to read and write.
   c. Possess a valid, picture identification.
   d. Be able to follow the POC with minimal supervision.
   e. Assist client appropriately with activities of daily living as related to personal care.
   f. Complete a probationary period determined by the employer with continued employment contingent on completion of a Personal Care in-service training program.
   i. Must submit to a program for the testing, prevention, and control of Tuberculosis annually.
3. Minimum Training Requirements for Personal Care Workers:
   The Personal Care training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing/or conducting the training. The Personal Care training program must be approved by the OA. Proof of the training must be recorded in the personnel file. Individual records will be maintained on each PCW to document that each member of the staff has met the requirements below.
   Minimum training requirements must include the following areas:
   a. Activities of daily living, such as,
      (1) bathing (sponge, tub)
      (2) personal grooming

(3) personal hygiene
(4) meal preparation
(5) proper transfer technique (assisting clients in and out of bed)
(6) assistance with ambulation
(7) toileting
(8) feeding the client

b. Home support, such as,
(1) cleaning
(2) laundry
(3) home safety

c. Recognizing and reporting observations of the client, such as,
(1) physical condition
(2) mental condition
(3) emotional condition
(4) prompting the client of medication regimen

d. Record keeping, such as,
(1) A service log signed by the client or family member/responsible person and PCW to document what services were provided for the client in relation to the POC. Submitting a written summary to the PCW Supervisor of any problems with client, client's home or family. The Supervisor in return should notify the case manager.

e. Communication skills
f. Basic infection control/Universal Standards
g. First aid emergency situations
h. Fire and safety measures
i. Client rights and responsibilities
j. Other areas of training as appropriate or as mandated by Medicaid, or the OA

4. The DSP will be responsible for providing a minimum of twelve (12) hours of relevant in-service training per calendar year for each PC Worker. In-service training is in addition to PC Worker orientation training. For PC Workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a PC Worker.
5. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.
6. Topics for specific in-service training may be mandated by the OA.
7. In-service training may entail demonstration of providing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs are limited to four (4) hours annually and must be approved for content and credit hours by the OA, prior to the planned training. The DSP shall submit proposed program(s) to the OA at least forty-five (45) days prior to the planned implementation.
8. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the twelve (12) hours required in-service for all PC Workers each calendar year.
9. The DSP Agency shall maintain records on each employee, which shall include the following:
a. Application for employment
b. Job description;
c. Statewide criminal background checks and references;
d. Record of health (annual tuberculin tests);
e. Record of pre-employment and in-service training;
(For PC Supervisor validation of required CEUs for licensure will be accepted.)

f. Orientation;
g. Evaluations;
h. Supervisory visits;
i. Copy of photo identification;
j. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;
k. Other forms as required by state and federal law, including agreements regarding confidentiality.

Section 10.12.4 - Procedures for Service are as follows

1. The case manager will submit a Service Authorization Form and POC to the DSP Agency authorizing Personal Care Service and designating the units, frequency, beginning and ending dates of service, and types of duties in accordance with the individual client's needs.
2. The DSP Agency will initiate PC Service within three (3) working days of the designated START DATE on the Service Authorization Form in accordance with the following:
   a. Services must **not** be provided prior to the authorized start date as stated on the Service Authorization Form.
   b. The DSP Agency will adhere to the services and schedule as authorized by the case manager on the Service Authorization Form. No payment will be made for services unless authorized and listed on the POC.
3. Provision of Service Authorized:
   a. Personal Care Service cannot be provided at the same time other authorized waiver services are being provided except case manager.
   b. Personal Care Workers will maintain a separate service log for each client to document their delivery of services.
      (1) The Personal Care Worker shall complete a service log that will reflect the types of services provided, the number of hours of service, and the date and time of the service.
      (2) The service log must be signed upon each visit by the client, or family member/responsible party and the PC Worker. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Personal Care Worker must document the reason the log was not signed by the client or family member/responsible party.
      (3) The service log will be reviewed and signed by the Personal Care Supervisor at least once every two (2) weeks. Service logs will be retained in the client's file.
      (4) Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.
   c. Services provided by relatives or friends may be covered only if relatives or friends meet qualifications for providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to ensure that payment is made to the relatives or friends as providers only in return for personal care services. Additionally, there must be

adequate justification as to why the relative or friend is the provider of care and there is documentation in the case management file showing that the family member is a qualified provider and the lack of other qualified providers in remote areas. The case manager will conduct an initial assessment of qualified providers in the area of which the client will be informed. The case manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The case manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for clients living in a remote area.

4. Monitoring of Service:
   PC Service must be provided under the supervision of the registered nurse or licensed practical nurse who meets the requirements of D.1. and will:
   a. Make the initial visit to the client's residence prior to the start of PC Service for the purpose of reviewing the POC providing the client written information regarding rights and responsibilities and how to register complaints, and discussing the provisions and supervision of the service(s)."
      The initial visit should be held at the client's place of residence and should include the case manager, the PC Supervisor, the client, and the caregiver, if feasible. It is advisable to also include the PC Worker in the initial visit.
   b. Be immediately accessible by phone during the time PC Service is being provided. Any deviation from this requirement must be prior approved in writing by the OA and AMA. If this position becomes vacant the OA and AMA must be notified within 24 hours when the position becomes vacant.
   c. Provide and document supervision of, training for, and evaluation of PCWs according to the requirements in the approved waiver document.
   d. Provide on-site (client's residence) supervision of the PCW at a minimum of every sixty (60) days for each client. Supervisory visits must be documented in the individual client record. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the PCW. In the event the on-site supervisory visit cannot be completed in a timely manner due to the client's being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Personal Care Service. Documentation regarding this action should be in the DSP client record. Client must be present for visit.
   e. The DSP must complete the sixty (60) day supervisory review which includes, at a minimum, assurance that the services are being delivered consistent with the POC and the Service Authorization Form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. A copy of the supervisory visit must be submitted to the case manager within ten (l0) calendar days after the sixty (60) day supervisory review. In the event the client is not available during the time the visit would have normally been made, the review must be completed within five (5) working days of the resumption of PC Service.
   f. Assist PCWs as necessary as they provide individual Personal Care Service as outlined in the POC. Any supervision/assistance given must be documented in the individual client's record.
   g. The PC Supervisor must provide direct supervision of each PC Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the PC Worker's personnel record.

(1) Direct supervision may be carried out in conjunction with an on-site supervisory visit.
(2) Client & PCW have to be present
The PC Supervisor will provide and document the supervision, training, and evaluation of PC Workers according to the requirements in the approved Waiver Document.

5. Missed Visits and Attempted Visits
   a. Missed Visits
      (1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.
      (2) The DSP shall have a written policy assuring that when a Personal Care Worker is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary/or reduced by the DSP.
      Clients who are designated by the case manager as being at-risk should be given first priority when Personal Care Service visits must be temporarily prioritized and
         a) If the Supervisor sends a substitute, the substitute will complete and sign the service log after finishing duties.
         b) If the Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Personal Care Worker.
      (3) The DSP will document missed visits in the client's files.
      (4) Whenever the DSP determines that services cannot be provided to an at-risk client as authorized, the case manager must be notified by telephone immediately. All missed/attempted visits for one week and the reason for the missed/attempted visit must be reported in writing on the **"Weekly Missed/Attempted Visit Report"** form to the case manager on Monday of each week. Any exception to the use of this form must be approved by the OA and AMA.
      (5) The DSP may **not** bill for missed visits.
   b. Attempted Visits
      (1) An attempted visit occurs when the PCW arrives at the home and is unable to provide services because the client is not at home or refuses services.
      (2) If an attempted visit occurs:
         - The DSP may **not** bill for the attempted visits.
         - The Supervisor will contact the client to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.
         - The DSP will notify the case manager promptly whenever an attempted visit occurs and will notify the case manager within one (1) working day after the second attempted visit whenever two (2) attempted visits occur within the SAME week.

6. Changes in Services
   a. The DSP will notify the case manager within one (1) working day of the following changes:
      (1) Client's condition and/or circumstances have changed and the POC no longer meets the client's needs;
      (2) Client does not appear to need Personal Care Service;
      (3) Client dies or moves out of the service area;
      (4) Client indicates Personal Care Service is not wanted;
      (5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided.

b. The case manager will notify the DSP immediately if a client becomes medically or financially ineligible for waiver services.

c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the POC, the DSP shall contact the case manager to discuss having these duties added.
   (1) The case manager will review the DSP's request to modify services and respond within one (1) working day of the request.
   (2) The case manager will approve any modification of duties to be performed by the PCW and re-issue the Service Authorization Form accordingly.
   (3) Documentation of any change in a POC will be maintained in the client's file.
      a) If the total number of hours of service is changed, a new Service Authorization Form is required from the case manager.
      b) If the types or times of services are changed, a new Service Authorization Form is required from the case manager.
      c) If an individual declines PC Service or has become ineligible for services, a Service Authorization Form for termination is required from the case manager.

7. Documentation and Record-Keeping
   a. The DSP shall maintain a record keeping system for each client that documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available to Medicaid, the OAs, or other agencies contractually required to review information upon request.
      The DSP shall maintain a file on each client, which shall Include the following:
      (1) A current HCBS application;
      (2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Personal Care visits for the client;
      (3) Documentation of client specific assistance and/or training rendered by the Supervisor to a Personal Care Worker;
      (4) All service logs;
         a) The service log must be reviewed and initialed by the Nurse Supervisor at least once every two (2) weeks.
      (5) Records of all missed or attempted visits;
      (6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken; and,
      (7) Evaluations from all 60 day on-site supervisory visits to the client;
      (8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;
      (9) Initial visit for in-home services;
      (10)Any other notification to case manager;
   b. Permission statements to release confidential information, as applicable. The DSP will retain a client's file for at least five (5) years after services are terminated.
   c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

Section 10.12.5 - Rights, Responsibilities, and Service Complaints are as follows:

1. The OA has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of PC Service provided and will provide information about how to register a complaint with the case manager as well as AMA.
    a. Complaints which are made against PCW will be investigated by the DSP Agency and documented in the client's file.
    b. All complaints which are to be investigated will be referred to the PCW Supervisor who will take appropriate action.
    c. The PCW Supervisor will take any action necessary and document the action taken in the client's and/or the employee's files, whichever is most appropriate based on the nature of the complaint.
    d. The PCW Supervisor will contact the case manager by letter or telephone about any complaint and any corrective action taken.
3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

Section 10.12.6 - Administrative Requirements are as follows

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the OA within three (3) working days of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.
2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the OA at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the OA.
3. Administrative and supervisory functions shall **not** be delegated to another agency or organization.
4. A list of the members of the DSP's governing body shall be made available to the OA or AMA upon request
5. The DSP Agency must maintain an annual operating budget which shall be made available to the OA and AMA upon request.
6. The DSP Agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the OA and/or AMA.
7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the OA and/or its agents.
8. The DSP Agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.

9. The DSP shall provide its regularly scheduled holidays to the OA. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.
10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the OA contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.
11. Any DSP staff, including administrative, that have any direct client contact must participate in a program for testing, prevention, and control of Tuberculosis annually.

Section 10.12.7 - Provider Experience is as follows:
Providers of Personal Care Service must meet all provider qualifications prior to rendering the Personal Care Service.

All personnel with direct client contact or access to client information must have complete reference verification and statewide criminal background checks on file prior to client contact or access to client information.

Section 10.13: Private Duty Nursing

Private Duty Nursing services are available to clients who need care that can only be provided by a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) and which is medically necessary to treat or ameliorate medical conditions identified as a result of an EPSDT screening.

Section 10.14: Respite Care – Skilled

A. Definition
Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of, or need for relief of those persons normally providing the care.

Skilled or Unskilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the client's household.

Respite Care is not an entitlement. It is based on the needs of the individual client as reflected in the POC.

B. Objective
The objective of Respite Care is to provide temporary care for clients who live at home and are cared for by their families or other informal support systems. This service will provide temporary, short term relief for the primary caregiver, and continue the supervision and supportive care necessary to maintain the health and safety of waiver clients. Respite Care is intended to supplement, not replace care provided to waiver clients.

Skilled or Unskilled Respite is provided to clients who have a physical, mental, or cognitive impairment that prevents them from being left alone safely in the absence or availability of the primary caregiver.

C. Description of Service to be Provided

1. The unit of service is 15 minutes of direct Respite Care provided in the client's residence. The amount of time does not include the Respite Care Worker's (RCW) transportation time to or from the client's residence or the Respite Care Worker's break or mealtime.
2. The number of units and services provided to each client is dependent upon the individual client's need as set forth in the client's POC established by the case manager. In-home Respite Service may be provided for a period not to exceed 720 hours per waiver year (October 1-September 30) in accordance with the provider contracting period. This limitation applies to skilled and unskilled respite or a combination.
   Medicaid will not reimburse for activities performed which are not within the scope of services defined.
3. As implied in the definition, Respite Care is for the relief of the family member or primary caregiver; therefore, there must be a primary caregiver identified for each client that uses the Respite Care Service. The primary caregiver does not have to reside in the residence; however, there must be sufficient documentation to establish that the primary caregiver to be relieved furnishes substantial care of the client.
4. This service must not be used to provide continuous care while the primary caregiver is working or attending school.
5. No payment will be made for services not documented on the POC and the Service Authorization Form.

6. The type of in-home respite (skilled or unskilled) provided to each client will be dependent upon the individual client's needs as established by the case manager and set forth in the client's POC.
   a. Skilled Respite:
      (1) Skilled Respite Service will provide skilled medical or nursing observation and services and will be performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act.
         a) Orders from the client's physician(s) are required annually and when any changes occur.
         b) It is the responsibility of the Skilled Respite Provider to obtain such physician orders for the skilled nursing services needed by the client.
      (2) In addition to providing supervision to the client, Skilled Respite may include, but is not limited to, the following activities:
         a) Assistance with activities of daily living (ADLs), such as,
            - Bathing, personal hygiene and grooming
            - Dressing
            - Toileting or activities to maintain continence
            - Preparing and serving meals or snacks and providing assistance with eating
            - Transferring
            - Ambulation
         b) Home support that is essential to the health and welfare of the recipient, such as,

- Cleaning
- Laundry
- Assistance with communication
- Home safety
  Home safety includes a general awareness of the home's surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the case manager for follow-up.

c) Skilled nursing services as ordered by the client's physician, including administering medications.
d) Skilled medical observation and monitoring of the client's physical, mental or emotional condition and the reporting of any changes.
e) Orienting the client to daily events.

b. Unskilled Respite:
(1) Unskilled Respite Services will provide and/or assist with activities of daily living and observations. Unskilled Respite will be performed by a Personal Care worker.
(2) In addition to providing supervision to the client, Unskilled Respite may include, but is not limited to, the following activities:
a) Meal or snack preparation, meal serving, cleaning up afterwards;
b) General housekeeping includes cleaning (such as sweeping, vacuuming, mopping, dusting, taking out trash, changing bed linens, defrosting and cleaning the refrigerator, cleaning the stove or oven, cleaning bathrooms); laundry (washing clothes and linen, ironing, minor mending); and, other activities as needed to maintain the client in a safe and sanitary environment;
c) Assistance with communication which includes placing phone within client's reach and physically assisting client with use of the phone and orientation to daily events;
d) Support for activities of daily living, such as,
- bathing
- personal grooming
- personal hygiene
- assisting clients in and out of bed
- assisting with ambulation
- toileting and/or activities to maintain continence

e) The Respite Care worker will ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the Respite Care Worker Supervisor as well as the case manager for follow-up;
f) Reporting observed changes in the client's physical, mental or emotional condition;
g) Reminding clients to take medication.

Note: Under no circumstances should any type of skilled medical or nursing service be performed by an Unskilled Respite worker.

D. Staffing

The DSP must provide all of the following staff positions through employment or sub contractual arrangements.

1. Skilled Respite Supervisors must meet the following qualifications and requirements:

a. Be a Registered Nurse (RN) who is currently licensed by the Alabama State Board of Nursing to practice nursing.
b. Have references which will be verified thoroughly and documented in the DSP personnel file. References must include statewide criminal background checks (including sex offender registry), previous employers, and the Nurse Aide Registry (if applicable).
c. Have at least two (2) years' experience as a Registered Nurse in public health, hospital, home health, or long term care nursing.
d. Have the ability to evaluate the Skilled Respite Worker (SR Worker) in terms of his or her ability to carry out assigned duties and his or her ability to relate to the client.
e. Have the ability to assume responsibility for in-service training for RCWs by individual instruction, group meetings or workshops.
f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or case manager's dissatisfaction, complaints or grievances regarding the provision of Respite Care Service.
g. Submit to a program for the testing, prevention, and control of tuberculosis annually.
h. Possess a valid, picture identification.

2. Skilled Respite Worker - A Licensed Practical Nurse (LPN) or Registered Nurse (RN) who meets the following requirements:
   a. Be currently licensed by the State of Alabama to practice nursing.
   b. Have at least two years of experience.
   c. Submit to a program for testing, prevention, and control of tuberculosis, annually.
   d. Be able to follow the POC with minimal supervision unless there is a change in the client's condition.
   e. Possess a valid, picture identification.
   f. Have references which will be verified thoroughly and documented in the DSP personnel file. References must include statewide criminal background checks (including sex offender registry), previous employers, and the Nurse Aide Registry (if applicable).
   Minimum Training Requirements for Skilled Respite Care Workers (LPN or RN):
   The DSP must assure Medicaid and the OA (OA) that the nurse has adequate experience and expertise to perform the skilled services and the care required by the client. Provide validation of CEUs for licensure.
3. Unskilled Respite Supervisors and workers must be qualified, trained, and employed by a Medicare/Medicaid certified Home Health Agency or other health care agencies approved by the Commissioner of AMA.
   Unskilled Respite Supervisors must have references which will be verified thoroughly and documented in the DSP personnel file. References must include statewide criminal background checks, previous employers, and the Nurse Aide Registry (if applicable).
4. Unskilled Respite Worker – USR workers must meet the following qualifications and requirements:
   a. Have references which will be verified and documented in the DSP personnel file. References must include statewide criminal background checks, previous employers, and Nurse Aide Registry (if applicable).
   b. Be able to read and write.
   c. Possess a valid, picture identification.
   d. Be able to follow the POC with minimal supervision.
   e. Assist client appropriately with activities of daily living.

f. Complete a probationary period determined by the employer with continued employment contingent on completion of an unskilled respite care in-service training program.
g. Must submit to a program for the testing, prevention, and control of tuberculosis annually.

Minimum Training Requirements for Unskilled Respite Care Worker:
The Unskilled Respite Care training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing/or conducting the training. The Unskilled Respite Care training program must be approved by the OA. Proof of the training must be recorded in the personnel file.

Individual records will be maintained on each USR worker to document that each member of the staff has met the requirements below.

Minimum training requirements must include the following areas:
a. Activities of daily living, such as,
   - bathing (sponge, tub)
   - personal grooming
   - personal hygiene
   - proper transfer technique (assisting clients in and out of bed)
   - assistance with ambulation
   - toileting
   - feeding the client
b. Home support, such as,
   - maintaining a safe and clean environment,
   - providing care which includes; individual safety, laundry, serve and prepare meals
   - household management
c. Recognizing and reporting observations of the client, such as,
   - Physical condition
   - mental condition
   - emotional condition
   - prompting the client of medication regimen
d. Record keeping, such as,
   - A service log signed by the client or family member/responsible person and USR Care worker to document what services were provided for the client in relation to the POC.
   - Submitting a written summary to the USR Care Worker Supervisor of any problems with client, client's home or family. The Supervisor in return should notify the case manager.
e. Communication skills
f. Basic infection control/Universal Standards
g. First aid emergency situations
h. Fire and safety measures
i. Client rights and responsibilities

j. Other areas of training as appropriate or as mandated by the OA

5. The DSP will be responsible for providing a minimum of 12 hours of relevant in-service training per calendar year for each USR worker.
   In-service training is in addition to USR Worker orientation training. For USR workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a USR Worker.
6. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.
7. Topics for specific in-service training may be mandated by the OA.
8. In-service training may entail demonstration of maintaining a safe and clean environment and providing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs are limited to four (4) hours annually and must be approved for content and credit hours by the OA, prior to the planned training. The DSP shall submit proposed program(s) to the OA least 45 days prior to the planned implementation.
9. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the 12 hours required in-service for all USR workers each calendar year.
10. The DSP Agency shall maintain records on each employee which shall include the following:
    a. Application for employment;
    b. Statewide criminal background checks and references
    c. Job description;
    d. Record of health with annual tuberculin tests for any staff member, including administrative, that has direct client contact;
    e. Record of pre-employment and annual in-service training;
       (1) For Skilled Respite Supervisors and Skilled Respite Workers validation of required CEUs for licensure will be accepted for in-service.
       (2) For USR Supervisor validation of required CEUs for licensure will be accepted.
    f. Orientation;
    g. Evaluations;
    h. Supervisory visits;
    i. Copy of photo identification;
    j. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;
    k. Other forms as required by state and federal law, including agreements regarding confidentiality.

E. Procedure for Service

1. The case manager will submit a Service Authorization Form and POC to the DSP Agency authorizing Respite Care designating the units, frequency, beginning date of service, and types of duties in accordance with the individual client's needs. This documentation will be maintained in the client's file.
2. The DSP Agency will initiate Respite Care within three (3) working days of the designated START DATE receiving the Service Authorization Form in accordance with the following:
   a. Services must not be provided prior to the authorized start date as stated on the Service Authorization Form.
   b. The DSP Agency will adhere to the services and schedule as authorized by the case manager on the Service Authorization Form.

c. No payment will be made for services unless authorized and listed on the POC.
d. The DSP will retain a client's file for at least five (5) years after services are terminated.

3. Provision of Service authorized:
   a. Respite Care cannot be provided at the same time other authorized waiver services are being provided with the exception of Case Management.
   b. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide. There must be strict controls to assure that payment is made to the relatives or friends as providers only in return for respite care services. Additionally, there must be adequate justification as to why the relative or friend is the provider of care and there is documentation in the case management file showing that the family member is a qualified provider and the lack of other qualified providers in remote areas. The case manager will conduct an initial assessment of qualified providers in the area of which the client will be informed. The case manager must document in the client's file the attempts made to secure other qualified providers before a relative or friend is considered. The case manager, along with the DSPs, will review the compiled information in determining the lack of qualified providers for client's living in a remote area.
4. Respite Care Worker will maintain a separate service log for each client to document their delivery of services.
   a. The Respite Care Worker shall complete a service log that will reflect the types of services provided, the number of hours of service, and the date and time of the service.
   b. The service log must be signed upon each visit by the client, or family member/responsible party. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Respite Care Worker must document the reason the log was not signed by the client or family member/responsible party.
   c. The Skilled Respite Worker must fully document the skilled nursing services that were authorized by the client's physician and performed for the client during each visit in which Skilled Respite was provided.
   d. The service logs for Unskilled Respite and the documentation forms for Skilled Respite will be reviewed and signed by the Unskilled or Skilled Respite Supervisor respectively at least once every two (2) weeks. Daily service logs and documentation forms will be retained in the client's file.
   e. Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.
   f. The DSP Supervisor should notify the case manager in writing regarding any report or indication from the DSP Worker regarding a significant change in the client's physical, mental or emotional health. The DSP Supervisor should document such action in the DSP client file.

5. Monitoring of Service:
   Unskilled Respite Care must be provided under the supervision of the Registered Nurse or Licensed Practical Nurse who meets the requirements of D.1.b.-h. and will:
   a. Make an initial visit to the client's residence prior to the start of Respite Care for the purpose of reviewing the POC, providing written information to the client regarding rights and responsibilities, how to register complaints, and discussing the provisions and supervision of the service(s)."
   b. Be immediately accessible by phone. Any deviation from this requirement must be prior approved in writing by the OA and AMA. If this position becomes vacant, the OA and AMA must be notified within 24 hours.
   c. Provide and document supervision of, training for, and evaluation of Unskilled Respite Care Workers according to the requirements in the approved waiver document.
   d. Provide on-site (client's residence) supervision at a minimum of every 60 days for each client. Supervisory visits must be documented in the individual client record. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the Unskilled Respite Care Worker. Client must be present for visit.
   e. Assist Unskilled Respite Care Workers as necessary as they provide individual Respite Service as outlined by the POC. Any supervision/assistance given must be documented in the individual client's record.
   f. The Skilled Respite Supervisor will provide on-site (client's residence) supervision at a minimum of every 60 days for each client. Supervisory visits must be documented in the individual client record. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the Skilled Respite Care Worker. Client must be present for visit.
   g. The SR and USR Supervisor must provide direct supervision of each SR and USR Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the Worker's personnel record.
      - Direct supervision may be carried out in conjunction with an on-site supervisory visit.
      - Client and worker have to be present.
        The SR and USR Supervisor will provide and document the supervision, training, and evaluation of SR and USR Workers according to the requirements in the approved Waiver Document.
6. Missed Visits and Attempted Visits
   a. Missed Visits
      (1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.
      (2) The DSP shall have a written policy assuring that when a Respite Care Worker is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary.
         a) If the Supervisor sends a substitute, the substitute will complete and sign the service log after finishing duties.
         b) If the Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Respite Care Worker.
      (3) The DSP will document missed visits in the client's files.
      (4) Whenever the DSP determines that services cannot be provided as authorized, the case manager must be notified by telephone immediately. All missed visits must be

reported in writing on the "Weekly Missed/Attempted Visit Report" form to the case manager on Monday of each week.

(5) The DSP may not bill for missed visits.

b. Attempted Visits

(1) An attempted visit occurs when the Respite Care Worker arrives at the home and is unable to provide services because the client is not at home or refuses services.

(2) If an attempted visit occurs:

a) The DSP may not bill for the attempted visits.

b) The Supervisor will contact the client to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.

c) The DSP will notify the case manager within one (1) day after second attempted visit whenever two attempted visits occur within the SAME week.

7. Changes in Services

a. The DSP will notify the case manager within one (1) working day of the following changes:

(1) Client's condition and/or circumstances have changed and the POC no longer meets the client's needs;

(2) Client does not appear to need Respite Care;

(3) Client dies or moves out of the service area;

(4) Client indicates Respite Care Service is not wanted;

(5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided.

b. The case manager will notify the DSP immediately if a client becomes medically and financially ineligible for waiver services.

The case manager must verify Medicaid eligibility on a monthly basis.

c. If the DSP identifies additional duties that would be beneficial to the client's care, but are not specified on the POC, the DSP shall contact the case manager to discuss having these duties added.

(1) The case manager will review the DSP's request to modify services and respond within one (1) working day of the request.

(2) The case manager will approve any modification of duties to be performed by the Respite Care and re-issue the Service Authorization Form accordingly, if he/she concurs with the request.

(3) Documentation of any changes in a POC will be maintained in the client's file.

a) If the total number of hours of service is changed, a new Service Authorization Form is required from the case manager.

b) If the types or times of services are changed, a new Service Authorization Form is required from the case manager.

c) If an individual declines Respite Care or has become ineligible for services, a Service Authorization Form for termination is required from the case manager.

8. Documentation and Record-Keeping

a. The DSP shall maintain a record keeping system which documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available to Medicaid, the OAs, or other agencies contractually required to review information upon request.

The DSP shall maintain a file on each client, which shall include the following:

(1) A current HCBS application;

(2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Respite Care visits for the client;
(3) All service logs;
- The service log must be reviewed and initialed by the Nurse Supervisor at least once every two (2) weeks.

(4) Records of all missed or attempted visits;
(5) Records of all complaints lodged by clients or family members/responsible parties and any actions taken;
(6) Evaluations from all 60 day on-site supervisory visits to the client;
(7) The Service Authorization Form notifying the DSP Agency of termination, if applicable;
(8) The name of the primary caregiver.

b. The DSP will retain a client's file for at least five (5) years after services are terminated.
c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The case manager has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.
2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Respite Care Service provided and will provide information about how to register a complaint with the case manager as well as AMA.
   a. Complaints which are made against Respite Care Workers will be investigated by the DSP and documented in the client's file.
   b. All complaints to be investigated will be referred to the Respite Care Worker Supervisor who will take appropriate action.
   c. The Respite Care Worker Supervisor will take any action necessary and document the action taken in the client's and employee's files.
   d. The Respite Care Worker Supervisor will contact the case manager by letter or telephone about any complaint and any corrective action taken.
3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have completed with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the OA within (3) working days of a change in the agency administrator, address, or phone number.
2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the OA at the time the contract is

implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the OA.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.
4. A list of the members of the DSP's governing body shall be made available to the OA and/or AMA upon request.
5. The DSP Agency must maintain an annual operating budget which shall be made available to the OA and/or AMA upon request.
6. During the life of the contract the DSP Agency shall acquire and maintain contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the OA and/or AMA.
7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the OA and/or its agents.
8. The DSP Agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.
9. The DSP shall provide its regularly scheduled holidays to the OA. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.

10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the OA contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

H. Provider Experience

Providers of Respite Care must meet all provider qualifications prior to rendering the Respite Care Service.

All personnel with direct client contact or access to client information must have complete reference verification and statewide criminal background checks on file prior to client contact or access to client information.

Section 10.15: Transitional Assistance

Service Definition *(Scope):*

Transitional assistance services and expenses consists of the following items, when appropriate and necessary for the participant's discharge from a nursing facility and safe transition to the community:

1. Security deposits that are required to obtain a lease on an apartment or home;
2. Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
3. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;

4. Household services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy;
5. Moving expenses

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Conditions of Payment: To qualify for payment as transitional assistance under the ACT Waiver, expenses must be:

1. Authorized and included in the participant's service plan;
2. Incurred within 60 days before a participant's discharge form a nursing facility or hospital or another provider-operated living arrangement; and
3. Necessary for the participant's safe transition to the community.
4. Transitional Assistance Services cannot exceed $1,500.

Non-payable Services and Expenses: Transitional assistance does not include expenses:

1. For monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for pure diversion or recreational purposes;
2. For residential facilities that are owned or leased by and ACT waiver provider; or
3. That are not necessary for the participant's safe transition to the community.

Service Delivery Method:
Provider Managed
Provider Category: Agency
Provider Type: Business Vendor
Provider Qualifications
License *(specify)*: Business License
Other Standard *(specify):*
Verification of Provider Qualifications/Entity Responsible for Verification: Operating Agency
Frequency of Verification: As Required
Provider Category:
Individual
Provider Type: Business Vendor
Provider Qualifications
License *(specify)*: Business License
Verification of Provider Qualifications/Entity Responsible for Verification: Operating Agency case manager
Frequency of Verification: At initial enrollment and annually

APPENDIX A
Acronyms & Accepted Abbreviations

Commonly Used Abbreviations

AAA	*Area Agency on Aging*	Federal agencies established under the Older Americans Act to serve the needs of people over the age 60. Every state has AAAs whose goals are to promote independent living in the community
ACL	*Administration for Community Living*	The Administration for Community Living (ACL) is part of the U.S. Department of Health and Human Services. It combines the Administration on Aging, the Administration on Intellectual and Developmental Disabilities, and the HHS Office on Disability to serve as the Federal agency responsible for improving access to community supports and promotes utilizing resources on the unique needs of older Americans and people with disabilities across the lifespan.
ADA	*Americans with Disabilities Act*	Law that prohibits discrimination based on a disability.
ADS	*Adult Day Services*	Social and health services for older adults who need care and supervision during the day
ADLs	*Activities of Daily Living*	The basic tasks of everyday living that include bathing, dressing and toileting
AoA	*Administration on Aging*	The Administration on Aging (AOA) is the principal agency of the U.S Department of Health and Human Services designated to carry out the provisions of the Older Americans Act of 1965 (OAA).
APS	*Adult Protective Services*	A division at the Department of Human Resources that exists to protect elderly and disabled adults from abuse, neglect, and exploitation. It also prevents unnecessary institutionalization when possible.
ADRC	*Aging and Disability Resource Centers*	Aging and Disability Resource Centers (ADRCs) are part of a national initiative put in place by ACL to provide access to information and assistance for older adults, individuals with disabilities and their caregivers.
C+C	*Cash and Counseling*	A program that allows consumers more control over the goods and services that they feel necessary to live independently
CIL	*Centers for Independent Living*	Community-based living centers administered by individuals who live with disability
CMS	*Centers for Medicare & Medicaid Services*	The Centers for Medicare & Medicaid Services, CMS, is part of the Department of Health and Human Services (HHS). Medicare, Medicaid, the

		Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace are the programs included as part of CMS.
DD	*Developmental Disability*	Lifelong disabilities that stem from mental/or physical impairments that occurred at birth or childhood
DE	*Dual Eligible*	The term used to describe people who are eligible for both Medicare and Medicaid. People receiving Medicare who meet federal poverty levels are also eligible to receive services under the Medicaid Program
EA	*Elder Abuse*	Any infliction of physical, mental, or psychological harm done to a person over age 60. It also includes neglect, self-neglect, and financial or economic exploitation of a person
FPL	*Federal Poverty Level*	The level of income set by the federal government that entitles people to services under Medicaid and other federal and state programs
HCBS	*Home and Community Based Services*	Home and community-based services (HCBS) is a program that allows Medicaid clients to receive services in their own home instead of an institution.
IADLs	*Instrumental Activities of Daily Living*	The more complex activities required for the daily living such as using the telephone, shopping, cooking, managing finances, doing house work
LEP	*Limited English Proficiency*	Those persons who speak little or no English.
AMA	*Alabama Medicaid Agency*	The Alabama Medicaid Agency is the entity responsible for managing the Medicaid program which is a health program for low-income families and individuals that is funded by federal and state governments.
SHIP	*State Health Insurance Program*	SHIP is a program of free health benefits counseling service for Medicare beneficiaries and their families or caregivers.
SLMB	*Specified Low-Income Medicare Beneficiary*	A program under Medicaid that pays Medicare premiums, and in some cases, Medicare deductibles and co-insurance.
SNF	*Skilled Nursing Facility*	An institution that provides skilled nursing care.
SUA	*State Unit on Aging*	State Units on Aging (SUA) administer and manage benefits and programs for older adults and their families. The allocation of funding to each SUA depends on the number of persons over the age of 60 residing in the state.

APPENDIX B

HCBS DSP/ADH Forms

Alabama Department of Senior Services Medicaid Waiver Program

Individual Client Billing

Client Name
Medicaid Number
AAA/COG/RPC
Direct Service Provider

CODES
A - Homemaker
B - Personal Care
C - Respite/Unskilled
D - Case Management
E - Respite/Skilled
F - Adult Day Health
G - Companion
H - Home Delivered Meals
I - Shelf Stable Meals
J - Breakfast Meals
K- Skilled Nursing (LPN)
L- Skilled Nursing (RN)
M - Personal Assistant Service

This is to certify that the following information is true, accurate and correct.

I am certifying to the Alabama Medicaid Agency, that the services listed herein, were provided to the above name client, on the dates specified.

_____

Authorized Signature

_____

Date

Month/Year

Date Service Delivered	Units of Service											
	A	B	C	D	E	F	G	H	I	J	K	L
1st												
2nd												
3rd												
4th												
5th												
6th												
7th												
8th												
9th												
10th												
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22nd												
23rd												
24th												
25th												
26th												
27th												
28th												
29th												
30th												
31st												
Total												

HOUR CONVERSION TO UNITS												
1/4 UNITS												

Alabama Department of Senior Services Medicaid Waiver Programs

Service Provider Authorization

Service Provider	Name of Client	Case Manager	Phone

Check box if a missed visit will place this client at risk. ☐

- ☐ Initial Referral
- ☐ Redetermination
- ☐ Change
- ☐ Termination

Emergency/Disaster Priority

- ☐ Not Priority
- ☐ Priority – Client Lives Alone
- ☐ Priority Advanced - Medical Need

Diagnosis/Diet Limitations

Homemaker

Frequency(s)	
Begin Date	
End Date	

- ☐ Make bed/Change linen
- ☐ Dust/ Sweep/Vacuum
- ☐ Clean/Defrost Refrig.
- ☐ Clean stove/oven
- ☐ Damp mop
- ☐ Wash dishes
- ☐ Empty trash
- ☐ Meal/snack preparation
- ☐ Clean bathroom
- ☐ Clean living area
- ☐ Wash/dry clothes
- ☐ Other …

- ☐ Iron/mend clothes
- ☐ Prescribed diet (assist)
- ☐ Grocery shopping
- ☐ Pick up medications
- ☐ Remind to take Meds.
- ☐ Pay bills
- ☐ Phone (assist with use)
- ☐ Letters (read/write/mail)
- ☐ Observe/report on client
- ☐ Ensure home safety
- ☐

Comments

The provision of services in excess of that indicated above will not be reimbursed. Please notify the case manager if the service schedule needs changing.

Authorized Signature	**Date**

Personal Care

Frequency(s)	
Begin Date	
End Date	

- ☐ Bathe client
- ☐ Skin/hair/oral
- ☐ Nail care
- ☐ Shave
- ☐ Dress client
- ☐ Bowel/bladder
- ☐ Turn client
- ☐ Make bed/Change linen
- ☐ Observe/report on client
- ☐ Other …

- ☐ Meal/snack preparation
- ☐ Feed client
- ☐ Housekeeping (light)
- ☐ Laundry (light)
- ☐ Transfer (bed/chair)
- ☐ Ambulation (assist)
- ☐ Toileting/continence
- ☐ Medications (remind)
- ☐ Ensure home safety

Companion

(supervise, remind, assist or accompany)

Frequency(s)	
Begin Date	
End Date	

- ☒ Supervise/observe…
- ☐ Housekeeping (light)
- ☐ Laundry (assist/sup.)
- ☐ Bathe/groom/hygiene
- ☐ Toileting/continence
- ☐ Other …

- ☐ Meal/snack (remind)
- ☐ Medications (remind)
- ☐ Grocery (accompany)
- ☐ Medical (accompany)
- ☐ Ensure home safety

MW-13A 4/2015 ☐ E&D Waiver ☐ 530 Waiver ☐ ACT Waiver

Alabama Department of Senior Services Medicaid Waiver Programs

Service Provider Authorization

Service Provider	Name of Client	Case Manager	Phone

Check box if a missed visit will place this client at risk. ☐

- ☐ Initial Referral
- ☐ Redetermination
- ☐ Change
- ☐ Termination

Emergency/Disaster Priority

- ☐ Not Priority
- ☐ Priority – Client Lives Alone
- ☐ Priority Advanced - Medical Need

Diagnosis/Diet Limitations

Unskilled Respite		Skilled Respite	
	Frequency(s)		Frequency(s)
	Begin Date		Begin Date
	End Date		End Date

PC Worker Duties		RN or LPN Duties	
☐ Make bed/Change linen	☐ Empty trash	☒ Supervise/observe…	
☐ Meal/snack preparation	☐ Wash/dry clothes	☐ Bathe client	☐ Meal/snack preparation
☐ Dust/sweep/vacuum	☐ Iron/mend clothes	☐ Skin/hair/oral care	☐ Feed client
☐ Damp mop	☐ Phone (assist with use)	☐ Nail care	☐ Housekeeping (light)
☐ Clean/defrost refrig.	☐ Medications (remind)	☐ Shave	☐ Laundry (light)
☐ Clean stove/oven	☐ Prescribed diet (assist)	☐ Dress client	☐ Transfer (bed/chair)
☐ Wash dishes	☐ Letters (write & mail)	☐ Bowel/bladder	☐ Ambulation (assist)
☐ Clean bathroom	☐ Ambulation (assist)	☐ Turn client	☐ Administer medications
☐ Clean living area	☐ Transfer (bed/chair)	☐ Make bed/Change linen	☐ Observe/report on client
☐ Bath/groom/hygiene	☐ Toileting/continence	☐ Orient to daily events	☐ Ensure home safety
☐ Skin/hair/oral care	☐ Turn client	☐ Other Skilled Needs…	
☐ Nail care	☐ Observe/report on client	**Comments**	
☐ Shave	☐ Ensure home safety		
☐ Dress client	☐ Orient to daily events		
		The provision of services in excess of that indicated above will not be reimbursed. Please notify the case manager if the service schedule needs changing.	
☐ Other …		**Authorized Signature**	**Date**

MW-13B 4/2015 ☐ **E&D Waiver** ☐ **530 Waiver** ☐ **ACT Waiver**

Alabama Department of Senior Services Medicaid Waiver Programs

Service Provider Authorization

Service Provider	Name of Client	Case Manager	Phone

Check box if a missed visit will place this client at risk. ☐

☐ Initial Referral
☐ Redetermination
☐ Change
☐ Termination

Emergency/Disaster Priority

☐ Not Priority
☐ Priority – Client Lives Alone
☐ Priority Advanced - Medical Need

Diagnosis/Diet Limitations

Adult Day Health

Frequency(s)	
Begin Date	
End Date	

Comments

- ☐ Monitor/report changes in client's health and functional level
- ☐ Supervise client's medication and observe for adverse reaction
- ☐ Monitor vital signs
- ☐ Teach positive health measures
- ☐ Assist with/encourage self-care
- ☐ Provide meals/snacks as per diet requirements
- ☐ Assist with/monitor personal hygiene
- ☐ Encourage participation in planned therapeutic social activities
- ☐ Assist with activities of daily living
- ☐ Provide information regarding emergency services
- ☐ Assist with social support activities
- ☐ Provide transportation to/from ADH center
- ☐ Support the client in following physician's orders
- ☐ Other …

The provision of services in excess of that indicated above will not be reimbursed. Please notify the case manager if the service schedule needs changing.

Authorized Signature	Date

MW-13C 4/2015 ☐ E&D Waiver ☐ 530 Waiver ☐ ACT Waiver

Alabama Department of Senior Services Medicaid Waiver Programs

Service Provider Authorization

Service Provider	Name of Client	Case Manager	Phone

Check box if a missed visit will place this client at risk. ☐

☐ Initial Referral
☐ Redetermination
☐ Change
☐ Termination

Emergency/Disaster Priority

☐ Not Priority
☐ Priority – Client Lives Alone
☐ Priority Advanced - Medical Need

Diagnosis/Diet Limitations

Skilled Nursing

☐ RN ☐ LPN

Frequency(s)	
Begin Date	
End Date	

Comments

☐ Administer medications and treatments prescribed by a licensed or otherwise legally authorized physician or dentist.

☐ Provide education and training designed to maintain access to a level of health care which is recognized by the nursing and medical professions as proper.

☐ Administer skilled services as ordered by the physician.

☐ Evaluate effectiveness of nursing service and report changes in client's condition as warranted.

☐ Provide skilled medical observation and monitor client's physical mental or emotional condition and report any changes.

☐ Orient the client to daily events.

☐ Observe home safety to include home's surroundings and report concerns to Case manager.

☐ Accompany client to medical appointments, if necessary.

☐ In an emergency, accompany client to ER via ambulance.

The provision of services in excess of that indicated above will not be reimbursed. Please notify the case manager if the service schedule needs changing.

Authorized Signature	**Date**

Alabama Department of Senior Services Medicaid Waiver Programs

Service Provider Authorization

Service Provider	Name of Client	Case Manager	Phone

Check box if a missed visit will place this client at risk. ☐

- ☐ Initial Referral
- ☐ Redetermination
- ☐ Change
- ☐ Termination

Emergency/Disaster Priority

- ☐ Not Priority
- ☐ Priority – Client Lives Alone
- ☐ Priority Advanced - Medical Need

Diagnosis/Diet Limitations

Personal Assistant Service

Frequency(s)	
Begin Date	
End Date	

Comments

*PA services assist an individual with physical disabilities to perform activities **on the job**. PAS is required, but is not limited to **assisting** with the following:*

- ☐ Essential shopping
- ☐ Transportation to and from work
- ☐ Eating
- ☐ Toileting
- ☐ Medication monitoring
- ☐ Entering or exiting doors
- ☐ Other…

The provision of services in excess of that indicated above will not be reimbursed. Please notify the case manager if the service schedule needs changing.

Authorized Signature	**Date**

Alabama Department of Senior Services Medicaid Waiver Programs

Service Provider Authorization

Service Provider	Name of Client	Case Manager	Phone

Check box if a missed visit will place this client at risk. ☐

☐ Initial Referral
☐ Redetermination
☐ Change
☐ Termination

Emergency/Disaster Priority

☐ Not Priority
☐ Priority – Client Lives Alone
☐ Priority Advanced - Medical Need

This participant is at risk, requiring Private Duty Nursing for health & safety to remain in the home

Diagnosis List/Diet Limitations

TAW Private Duty Nursing

☐ RN ☐ LPN

Frequency(s)	
Begin Date	
End Date	

☐ Medication list attached

☐ Administer medications and treatments prescribed by a licensed or otherwise legally authorized physician or dentist		☐ Bathe client
☐ Provide education and training designed to maintain access to a level of health care which is recognized by the nursing and medical professions as proper		☐ Grooming (Skin/ Hair/ Oral Care)
☐ Administer skilled services as ordered by the physician		☐ Nail care
☐ Evaluate effectiveness of nursing service and report changes in client's condition as warranted		☐ Toileting/ continence
☐ Provide skilled medical observation and monitor client's physical mental or emotional condition and report any changes		☐ Dress client
☐ Orient the client to daily events		☐ Turn client
☐ Observe home safety to include home's surroundings and report concerns to Case manager		☐ Feed client
☐ Accompany client to medical appointments, if necessary		☐ Suction
☐ In an emergency, accompany client to ER via ambulance	☐ Ambulation (assist)	☐ Transfer Assist (bed/chair)
☐ Other …	☐	

Comments

The provision of services in excess of that indicated above will not be reimbursed. Please notify the case manager if the service schedule needs changing.

Authorized Signature	Date

MW-13F 4/2015 ☐ **TA Waiver**

Alabama Department of Senior Services Medicaid Waiver Programs

Missed/Attempted Visit Report

Name of Service Provider	Name of AAA/COG/RPC	Name of Case Manager

Date of Visit	Name of Client	# Units Missed	Type of Visit	Type of Service
			☐ Missed ☐ Attempted	☐ Homemaker ☐ Personal Care ☐ Companion ☐ Unskilled Respite ☐ Skilled Respite ☐ Skilled Nurse LPN ☐ Skilled Nurse RN ☐ Adult Day Care
Reason/Explanation and/or Comments			Check Box if Client is at Risk! ☐	

Date of Visit	Same as above	# Units Missed	Type of Visit	Type of Service
			☐ Missed ☐ Attempted	☐ Homemaker ☐ Personal Care ☐ Companion ☐ Unskilled Respite ☐ Skilled Respite ☐ Skilled Nurse LPN ☐ Skilled Nurse RN ☐ Adult Day Care
Reason/Explanation and/or Comments			Check Box if Client is at Risk! ☐	

Date of Visit	Same as above	# Units Missed	Type of Visit	Type of Service
			☐ Missed ☐ Attempted	☐ Homemaker ☐ Personal Care ☐ Companion ☐ Unskilled Respite ☐ Skilled Respite ☐ Skilled Nurse LPN ☐ Skilled Nurse RN ☐ Adult Day Care
Reason/Explanation and/or Comments			Check Box if Client is at Risk! ☐	

Waiver Case Manager must be notified immediately when a missed visit and/or two (2) consecutive attempted visits occur. Complete a separate form for each client (multiple missed visits/services for the same client may be placed on one form) and send to Waiver Case Manager every Monday.

From: _____

MW-15 6/2012R

Date: _____

Alabama Department of Senior Services Waiver Programs

Client Rights and Responsibilities

I am certifying with my signature below that I have been read and/or have read my rights and responsibilities, and I agree to them as written herein.

Client Rights:

☐ **1.)** The client has the right to confidentiality concerning his/her personal affairs.

☐ **2.)** The client has the right to be treated with dignity and respect.

☐ **3.)** The client has the right to maintain his/her independence to the degree possible.

☐ **4.)** The client has the right to quality services delivered in a consistent and stable manner.

☐ **5.)** The client has the right to express grievances and to appeal decisions made by agencies.

☐ **6.)** The client has the right to be informed of resources available through the program.

☐ **7.)** The client has the right to be informed of the limitations of the program.

☐ **8.)** The client has the right of "Freedom of Choice".

☐ **9.)** The client has the right to participate in the development of the "Plan of Care".

☐ **10.)** The client has the right to reject services and be informed of the consequences of such actions.

Client Responsibilities:

☐ **1.)** The client and his/her family have the responsibility to cooperate with the case manager and the in-home workers and treat them with respect.

☐ **2.)** The client and his/her family have the responsibility to participate in the provision of care to the greatest extent possible.

☐ **3.)** The client and his/her family have the responsibility to report changes

in the client's situation to the case manager as soon as possible.

☐ **4.)** The client and his/her family have the responsibility to be at home when services are scheduled or to notify the service provider prior to the service date.

☐ **5.)** The client and his/her family have the responsibility to provide adequate food, personal and household supplies so that services may be performed.

☐ **6.)** The client and his/her family have the responsibility to secure proper medical care to the extent possible.

☐ **7.)** The client and his/her family have the responsibility to report inadequate services to the case manager.

☐ **8.)** The client and his/her family have the responsibility to sign verification of services only after ascertaining their accuracy.

(The Case Manager should go through this check list, item by item, with the client/caregiver checking off each item as it is discussed. Have the client /caregiver sign and date in the appropriate spaces below. Place a copy in the client's home, and the original in the client's case file.)

Client/caregiver _____ **Date** _____

Case manager _____ **Date** _____

Alabama Department of Senior Services Medicaid Waiver Programs

Complaint/Grievance Policy & Procedures

I am certifying with my signature below that I have been read and/or have read and understand the enclosed "Complaint/Grievance" Policy and Procedures.

POLICY

The client/caregiver or legal representative has the right to voice grievances and changes in service or staff without fear of restraint or discrimination. He/she has the right to express grievances by phone, in person or in writing to the Area Agency on Aging, Alabama Department of Senior Services and/or Alabama Medicaid Agency. Investigation of all complaints is initiated upon receipt.

PURPOSE

To allow the client/caregiver/representative to voice complaints or grievances about the availability, delivery or quality of care, staff, safety issues, discourtesy, discrimination, abuse of property, verbal abuse, sexual abuse, physical abuse, neglect, exploitation or any other item of concern to clients, families and legal representatives.

PROCEDURE

Clients/caregivers are informed about their right to express grievance upon program admission, program re-admission/redetermination and on an as needed basis. The client/caregiver is given a copy of this form and the "Fair Hearing" instructions form that lists the toll-free telephone number of the Alabama Medicaid Agency. The client/care giver is also given and has posted in the home, a copy of his/her case manager's telephone number and is encouraged to contact this person with any problems or complaints.

Upon receipt of a complaint/grievance, the case manager will gather facts, investigate the complaint/grievance and attempt to resolve the complaint to the satisfaction of the client/caregiver/representative. If the situation is not resolved, it will be forwarded to the "Lead Case Manager" or case manager supervisor for follow-up.

If the client/caregiver/representative is not satisfied, the complaint should go to the Director of Aging at the representative Area Agency on Aging for resolution.

If the matter is still not resolved to the client/caregiver/representative's satisfaction, the complaint/grievance should be forwarded to:

Program Chief or Administrator of Medicaid Waiver Services
Alabama Department of Senior Services
P.O. Box 301851
Montgomery, AL 36130-1851

Telephone 1-877-425-2243

If the Alabama Department of Senior Services has not resolved the client/caregiver/representative's concern to satisfaction, it may be expressed to:

Alabama Medicaid Agency
Long Term Care Division
P.O. Box 5624
Montgomery, AL 36103-5624

Telephone 1-800-362-1504

If there is still no satisfaction of the client/caregiver/representatives concerns, after attempted resolution between the Alabama Medicaid Agency's Long Term Care representative and the client/caregiver/representative, a fair hearing may be granted by the Alabama Medicaid Agency. Documentation of the above events will be placed in the client's case file and forwarded to ADSS at least quarterly.

(Case Manager, be sure that the client/caregiver has read and understands the above policy and procedures. Have the client /caregiver sign and date in the appropriate spaces below. Place a copy in the client's home, and place the original in the client's case file. In the event of reported abuse, neglect or exploitation, contact DHR and ADSS immediately.)

Client/caregiver _____ **Date** _____

Case manager _____ **Date** _____

Alabama Department of Senior Services Medicaid Waiver Programs

DSP/ADH LISTING OF ALL ADSS MW WAIVER CLIENTS

for

_____

(NAME OF DSP or ADH)

CLIENT NAME	CLIENT MEDICAID NUMBER	COUNTY OF RESIDENCE

MW-19 6/2012R

Alabama Department of Senior Services Medicaid Waiver Programs

ADH MW Waiver Client Attendance Calendar

Name of Client	Medicaid Number	Date

CA = client attended ADH **MV** = missed visit report on file **MVM** = missing missed visit report **H** = holiday, ADH closed

S	M	T	W	T	F	S

S	M	T	W	T	F	S

S	M	T	W	T	F	S

Alabama Department of Senior Services Medicaid Waiver Programs

Signature Card

Authorization is hereby given by the undersigned to the Alabama Department of Senior Services/Area Agency on Aging to keep my signature contained herein on file to be used as needed to determine legitimacy of any signature on any document submitted.

Please print name of client: (mandatory) **Medicaid Number** (mandatory)

_____ _____

_____ _____

Client's Signature **Date**

(In event the client is unable to sign, and if documentation that the caregiver has a power of attorney for the client is attached to this form, the caregiver may sign below for the client.)

Please print name of caregiver

_____

_____ _____

Caregiver's Signature **Date**

_____ _____

Witness or Case Manager's Signature **Date**

MW-27 6/2012R

Alabama Department of Senior Services Medicaid Waiver Programs

Intake/Referral

CLIENT INFORMATION

Name	Social Security #	Medicaid #

Address	City	County	Zip Code	Telephone #

Date of Birth	Doctor Name	Last Visit	Telephone	

Source of Income

☐SS ☐Full Medicaid ☐SSI ☐Deeming ☐QMB/SLMB/QI ☐Pension ☐Medicare Part A B C D

Does client have any of the following?

☐AIDS/HIV	☐Arthritis	☐COPD	☐HTN	☐Parkinson	☐Alcohol/Drug
☐Mental Illness	☐Renal Failure	☐Alzheimer's	☐Cancer	☐Diabetes	☐CHF
☐Mental Retardation	☐Seizure	☐Amputation	☐Heart Disease	☐ Paralysis	☐Blindness
☐Falls	☐CVA	☐Asthma	☐Obesity >>>>>>>Weight _____Height_____		
☐Cane	☐Walker	☐Wheelchair	☐Oxygen	☐Hoyer Lift	
☐CD 4 Count _____	☐Viral Load _____		☐Other_____		

☐Recent Hospitalization (date/s)_____ ☐NH (discharge date)_____

Current Services in the Home

☐Home Health ☐Hospice ☐DHR ☐Other_____

CAREGIVER INFORMATION

Name	Relationship	Telephone #

Address	City	State	County	Zip Code

Referral Source	Relationship	Telephone #

Name of Intake Person	Telephone #	Client Referred to...	Date

Comments:

☐ E&D Waiver ☐ 530 Waiver ☐ ACT Waiver

Alabama Department of Senior Services Medicaid Waiver Programs

Release of Information

Name of Client	Medicaid Number

Attending Physician

I authorize/request that my medical and/or financial information be released to the AAA/COG/RPC, ADSS, AMA and/or CMS for the purpose of determining my eligibility and/or continuing eligibility to receive Alabama Medicaid Elderly and Disabled Waiver Services.

_____

Applicant

_____

Date

Alabama Department of Senior Services Medicaid Waiver Programs

Appeal and Fair Hearing Instructions

IF A CLIENT IS DISSATISFIED WITH THE DECISION, WHAT CAN BE DONE ABOUT IT?

1. REQUEST AN APPEAL

The client has thirty (30) days from the effective date of the action to request an appeal. The client may notify the Alabama Department of Senior Services (ADSS) in writing giving the reason for the dissatisfaction and ask for an appeal. At the appeal meeting, the client will have the opportunity to present additional information in support of their case. The client may present the information or may be represented by a friend, relative, attorney or other spokes person of their choice.

If the client wishes to continue services while the case is in appeal status, a written request must be received by ADSS within ten (**10**) days of the effective date of The Notice of Action. The client should also notify their case manager that they wish to continue services.

If services are continued pending the outcome of the appeal and the decision is not in the client's favor, the Alabama Medicaid Agency may recover from the recipient or sponsor, the costs of all services paid after the initial effective date.

2. REQUEST FOR A FAIR HEARING

The Alabama Medicaid Agency will notify the client of the decision of the appeal. If the client is still dissatisfied, a fair hearing may be requested. A written request for a hearing must be filed within thirty (30) days following the notification of the decision. He/she, his/her legally appointed representative or other authorized person must request the hearing and give a correct mailing address. If the request for the hearing is made by someone other than the client, the client must make a definite statement that he/she has been authorized to do so by the client for whom the hearing is being requested. Information about the hearing will be forwarded and plans will be made for the hearing.

The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy which requires an automatic change adversely affecting some or all recipients.

MEDICAID ELIGIBILITY DIVISION POLICIES AND PROCEDURES IN COMPLIANCE WITH CIVIL RIGHTS ACT OF 1964 AND SECTION 504 OF THE REHABILITATION ACT OF 1973.

STATE OF ALABAMA MEDICAID AGENCY
LTC Division-Project Development
501 DEXTER AVENUE
P. O. BOX 5624
MONTGOMERY, ALABAMA 36103-5624

Alabama Department of Senior Services Medicaid Waiver Programs

SERVICE VOUCHER SUMMARY SHEET

Contractor	Contract Number	Month/Year

Services/Codes	Contract Rate Per Unit	# of Units Delivered	TOTAL COST
A - Homemaker	/15 min.		$
B – Personal Care	/15 min.		$
C – Respite (unskilled)	/15 min.		$
E – Respite (skilled)	/15 min.		$
F – Adult Day Health Care	/Day		$
G - Companion	/15 min.		$
K – Skilled Nursing (LPN)	/15 min.		$
L – Skilled Nursing (RN)	/15 min.		$
M – Personal Assistant	/15 min.		$
GRAND TOTAL			$

CERTIFICATION: *I certify that the above is true and accurate and request reimbursement for services administered under the Medicaid Waiver Program.*

CONTRACTOR:

Signature of Authorized Official

Title of Authorized Official

Date Report Submitted

AAA APPROVAL:

Signature of Authorized Official

Title of Authorized Official

Date of Approval

MW-8 4/2015 ☐ **E&D Waiver** ☐ **530 Waiver** ☐ **ACT Waiver**

Alabama Department of Senior Services Medicaid Waiver Programs

Billing Adjustments

AAA/COG/RPC	Month of Adjustment
Name of Client	**Adjusted Start Date**
Medicaid Number	**Adjusted End Date**
Claim Number	

Service Type	Original # Units Billed	Adjustment	Corrected Total
A - Homemaker			0
B - Personal Care			0
C - Respite/Unskilled			0
D - Case Management			0
E - Respite/Skilled			0
F - Adult Day Health			0
G - Companion			0
H - Home Delivered Meals			0
I - Shelf Stable Meals			0
J - Breakfast Meals			0
K - Skilled Nursing (LPN)			0
L - Skilled Nursing (RN)			0
M - Personal Assistant Service			0

_____

Authorized Signature

_____

Date

STATE OF ALABAMA
DEPARTMENT OF SENIOR SERVICES

RSA Tower Suite 350
201 Monroe Street
P.O. Box 301851
MONTGOMERY, AL 36130-1851

ROBERT J. BENTLEY
GOVERNOR

NEAL G. MORRISON
Commissioner

(334) 242-5743
FAX: (334) 242-5594
www.alabamaageline.gov

September 12, 2014

EDW NOTICE 14-03

TO: Executive Directors and Area Agencies on Aging

FROM: Robert E. Franklin, ADSS

THROUGH: Jean Stone R.N., Chief
LTC Programs, ADSS

SUBJECT: DSP Recoupment Procedures

Effective immediately the following policy is in effect:

ADSS will notify the AAA of any identified findings that require recoupment following our review of the AAA/DSP audit report. The AAA will compile the dollar amount billed and paid to the DSP for the identified findings. The AAA/DSP recoupment amount will be forwarded, in the form of a memorandum, from the AAA to ADSS with a breakdown of the total amount to be recouped. The AAA shall not submit adjusted billings (MW-9) to ADSS. ADSS will make the required adjustment with the AAA at the end of the Fiscal year.

Once approved by ADSS, the AAA will proceed with recoupment from the DSP. Please forward a copy of the DSP notification letter to ADSS. The AAA may allow the DSP to spread out payments over multiple months. The following language shall be included in the letter the DSP:

If you do not agree with the above action, you have the right to appeal. A written request for appeal must be made within 30 days to the:

Alabama Department of Senior Services
Medicaid Waiver Appeals Coordinator
P.O. Box 301851
Montgomery, Alabama 36130

If you have any questions, please contact this office.

JS/ref

Alabama Department of Senior Services Medicaid Waiver Programs

ADH Quality Performance Assessment

(Personnel File Review)

Name of Staff Member	Job Title of Staff Member	Hire Date of Staff Member	Audit Date

Name of Adult Day Health Provider	Name and Agency of Reviewer

A copy of the staff member's job description is present in the employee's file (should identify responsibilities, education and experience)?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member's personnel file contains documentation that references were verified **for those hired prior to 10/1/ 2007**)?	☐ Yes ☐ No ☐ N/A	Comments	
Staff members and all personnel with access to client information have proof that **statewide criminal background checks** are documented in the employee's personnel file and are prior to client contact or access to client information? (This pertains to employees hired as of 10/01/07.)	☐ Yes ☐ No ☐ N/A Date conducted:	Comments	
Staff members and all personnel with access to client information have proof that **sex offender checks** are documented in the employee's personnel file and are prior to client contact or access to client information? (This pertains to employees hired as of 6/30/2010.)	☐ Yes ☐ No ☐ N/A Date conducted:	Comments	
Staff members and all personnel with access to client information have proof that **nurse aide registry checks** are documented in the employee's personnel file and are prior to client contact or access to client information? (This pertains to employees hired as of 10/01/07.)	☐ Yes ☐ No ☐ N/A Date conducted:	Comments	
Staff members and all personnel with access to client information have proof that **previous employers and references are verified** and documented in the employee's personnel file and are prior to client contact or access to client information? (This pertains to employees hired as of 10/01/07.)	☐ Yes ☐ No ☐ N/A Date conducted:	Comments	
Staff member's file contains documentation that he/she submits to a program for the testing, prevention, and control of tuberculosis annually?	☐ Yes ☐ No ☐ N/A Dates read of last 2 tests:	Comments	
Staff member's personnel file contains an application for employment?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member's personnel file contains a record of pre-employment?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member's personnel file contains evaluations?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member's personnel file contains a copy of a valid, picture identification?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member has a valid Alabama driver's license (if transporting Adult Day Health clients)?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member meets orientation training requirements prior to service delivery?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member meets annual in-service training requirements? (These must include infection control updates. A four (4) hour annual limit for self-study i.e. videos/online is in effect.)	☐ Yes ☐ No ☐ N/A	Comments	
Staff member's file contains other forms as required by state and federal law including agreements regarding confidentiality?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member's file contains evidence of current CPR/first aid certification?	☐ Yes ☐ No ☐ N/A	Comments	
Staff member's file contains records of all complaints/incidents lodged by the client/family and action taken?	☐ Yes ☐ No ☐ N/A	Comments	
RN/LPN has current Alabama State Board of Nursing license?	☐ Yes ☐ No ☐ N/A	Comments	
RN/LPN has at least two (2) years experience as a Registered Nurse or Licensed Practical Nurse?	☐ Yes ☐ No ☐ N/A	Comments	
Director's personnel file contains documentation of education (high school diploma or equivalent)?	☐ Yes ☐ No ☐ N/A	Comments	

Additional Comments

(Note: Minimum 6 hrs annual in-service training must be in the areas listed below and include topic, name and title of trainer, objective of training, date of training, outline of content, length of training, list of trainees and location.)

- ☐ **Behavioral interventions, acceptance, and accommodation;**
- ☐ **Providing care and supervision including individual safety and non-medical care;**
- ☐ **First aid in emergency situations;**
- ☐ **Documenting client's participation;**
- ☐ **Fire and safety measures;**
- ☐ **Confidentiality;**
- ☐ **Client rights;**
- ☐ **Needs of the elderly and disabled population;**
- ☐ **Basic infection control/Universal Standards;**
- ☐ **Communication skills;**
- ☐ **Other areas of training as appropriate or as mandated by Medicaid and the Operating Agencies.**

Alabama Department of Senior Services Medicaid Waiver Programs

ADH Quality Performance Assessment

(Client/File Review)

Name of Client	Medicaid Number	Name of Case Manager	Audit Date

Name of Adult Day Health Provider	Frequency/Service(s) Authorized

Name and Agency of Reviewer	Period of Review

Does the client attend ADH four (4) or more hours per day on a regular basis?	☐ Yes ☐ No ☐ N/A	Comments	
Does the ADH provider administer medication to the client?	☐ Yes ☐ No ☐ N/A	Comments	
Does the clients' file contain a record of all medication administered to the client?	☐ Yes ☐ No ☐ N/A	Comments	
Both current and historical "Service Provider Authorization Form(s)" is/are present in the client/patient file?	☐ Yes ☐ No ☐ N/A	Comments	
The Service Provider Authorization Form contains number of units, frequency, begin date, and activities to be performed?	☐ Yes ☐ No ☐ N/A	Comments	
Services were initiated within three (3) working days of the designated "START DATE" on the Service Authorization Form? (Per Oct. 1, 2007 waiver renewal). (Prior to Oct. 1, 2007 within three (3) working days of "receipt of the Services Authorization Form")?	☐ Yes ☐ No ☐ N/A	Comments	
Were services started prior to the authorized start date on the Service Authorization Form?	☐ Yes ☐ No ☐ N/A	Comments	
Were services billed prior to the authorized start date on the Service Authorization Form?	☐ Yes ☐ No ☐ N/A	Comments	
The file contains a "new" Service Authorization Form for any change in number of hours, frequency, or type of service?	☐ Yes ☐ No ☐ N/A	Comments	
The file contains a Service Authorization Form to terminate services? (If applicable).	☐ Yes ☐ No ☐ N/A	Comments	
A complete/current copy of the HCBS application (to include the Plan of Care) is present in the client/patient file?	☐ Yes ☐ No ☐ N/A	Comments	
Does the file indicate that the client had a change in condition or the POC no longer meets the client's needs?	☐ Yes ☐ No ☐ N/A	Comments	
Did the ADH notify the case manager within one (1) working day of the change to the client's condition?	☐ Yes ☐ No ☐ N/A	Comments	
Did the case manager respond back to the ADH within one (1) working day of the notification by the DSP?	☐ Yes ☐ No ☐ N/A	Comments	
A signed copy of Complaint/Grievance Policy and Procedures form is in the file?	☐ Yes ☐ No ☐ N/A	Comments	
A signed copy of Client Rights and Responsibilities form is in the file?	☐ Yes ☐ No ☐ N/A	Comments	
A record of all complaints lodged by the client, family member or responsible party, and any action taken, is in the client/patient file, and followed up on per AMA requirements?	☐ Yes ☐ No ☐ N/A	Comments	
There is evidence on the first day of service the provider reviewed the POC, provided the client written information regarding rights and responsibilities and how to register complaints, and discussed the provisions and supervision of the service. (Effective May 1, 2008.)	☐ Yes ☐ No ☐ N/A	Comments	
A copy of monthly health screening(s) (nursing assessment) is/are present in the client/patient file? (Prior to May 1, 2008.)	☐ Yes ☐ No ☐ N/A	Comments	
A copy of monthly health screening(s) (nursing assessment) is/are completed that include, but are not limited to: checking vital signs, weighing clients if applicable and monthly health and nutritional teaching. (Effective May 1, 2008).	☐ Yes ☐ No ☐ N/A	Comments	
A copy of 60 day assessments and brief client summaries sent to the case manager, are present in the client/patient file?	☐ Yes ☐ No ☐ N/A	Comments	
The daily attendance/service log is in the client/patient file?	☐ Yes ☐ No ☐ N/A	Comments	
The daily attendance log is initialed daily and signed weekly by the client/patient?	☐ Yes ☐ No ☐ N/A	Comments	
The daily attendance log is reviewed and initialed at least every two (2) weeks by the ADH center director?	☐ Yes ☐ No ☐ N/A	Comments	
All missed visits are documented and sent to the case manager weekly (Monday) as required?	☐ Yes ☐ No ☐ N/A	Comments	
The billing corresponds with the attendance logs?	☐ Yes ☐ No ☐ N/A	Comments	

The billing corresponds with the missed visit reports?	☐ Yes ☐ No ☐ N/A	Comments	
The services billed match the services authorized?	☐ Yes ☐ No ☐ N/A	Comments	

ADHQPA-2 4/2015 ☐ **E&D Waiver** ☐ **ACT Waiver**

Alabama Department of Senior Services Medicaid Waiver Programs

ADH Quality Performance Assessment

(Administrative Review)

Name of Adult Day Health Provider	Name and Agency of Reviewer	Audit Date

The ADH provider has designated an individual to serve as the agency administrator?	☐ Yes ☐ No ☐ N/A	Comments	
The ADH agency has key staff, to include the agency administrator or ADH supervisor, present during this compliance audit?	☐ Yes ☐ No ☐ N/A	Comments	
The ADH Provider has at least one person trained to act on behalf of the Adult Day Health Director in his or her absence?	☐ Yes ☐ No ☐ N/A	Comments	
The ADH provider has an organizational chart showing chain of command and it is accessible to the staff?	☐ Yes ☐ No ☐ N/A	Comments	
The ADH provider has a written policy on infection control procedures and an ongoing infection control program in place?	☐ Yes ☐ No ☐ N/A	Comments	
The ADH provider has a written policy concerning client/patient confidentiality (HIPAA)?	☐ Yes ☐ No ☐ N/A	Comments	
The ADH provider has a written client/patient complaint and grievance policy and procedure?	☐ Yes ☐ No ☐ N/A	Comments	
Does the ADH administer medications to any client/patient?	☐ Yes ☐ No ☐ N/A	Comments	
Are the medications filled by a pharmacy and have physicians instructions written on the label?	☐ Yes ☐ No ☐ N/A	Comments	
Are the medications administered by a nurse (RN/LPN)?	☐ Yes ☐ No ☐ N/A	Comments	
The ADH Provider has a registered nurse (RN) or licensed practical nurse (LPN) available two hours per week or eight hours per month for consultation?	☐ Yes ☐ No ☐ N/A	Comments	
Does the ADH provide transportation for the ADH clients/patients?	☐ Yes ☐ No ☐ N/A	Comments	
Is the ADH in-service training pre-approved by the Operating Agency?	☐ Yes ☐ No ☐ N/A	Comments	
Does the ADH provider have documentation of current operating approval from Medicaid?	☐ Yes ☐ No ☐ N/A	Comments	
Has the ADH provider had a change in agency administrator, address or phone number?	☐ Yes ☐ No ☐ N/A	Comments	
If there was a change in administrator, address or phone number, was the Operating Agency notified?	☐ Yes ☐ No ☐ N/A	Comments	
Does the ADH provide group socialization and observe and assist the clients/patients with meals and eating?	☐ Yes ☐ No ☐ N/A	Comments	
Does ADH provider have incorporated in the procedures for the operation of the center, adequate safeguards to protect the health and safety of the clients in the event of a medical or other emergency, including natural disasters?	☐ Yes ☐ No ☐ N/A	Comments	
Does the ADH maintain adequate staff for the number of clients severed in the center?	☐ Yes ☐ No ☐ N/A	Comments	
The ADH has a written policy on handling fire evacuations?	☐ Yes ☐ No ☐ N/A	Comments	
Does the ADH provider conduct and document monthly fire and weather drills? (Documentation of drills shall include date, time, duration, number of clients' participating, number of staff participating and name of staff conducting the drill). (Effective May 1, 2008).	☐ Yes ☐ No ☐ N/A	Comments	
The ADH has current liability insurance which also covers volunteers (this is a requirement prior to enrollment as a provider)?	☐ Yes ☐ No ☐ N/A	Comments	

Additional Comments

ROBERT J. BENTLEY
GOVERNOR

STATE OF ALABAMA
DEPARTMENT OF SENIOR SERVICES

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May 25, 2011

EDW NOTICE 11-04

TO: Executive Directors and Area Agencies on Aging

FROM: Robert E. Franklin, Administrator
LTC Programs, ADSS

Through: Jean Stone R.N., Chief
LTC Programs, ADSS

SUBJECT: DSP Liability Insurance Requirements

Effective immediately is the attached AMA policy (WAV-36).

Please relay this information to your case managers.

If you have any questions, please contact this office.

REF

Attachment:

Alabama Medicaid Agency

Policy Title: HCBS Waiver Requirements Regarding DSP Liability Insurance **Policy Number:** WAV-36 **Attachments:** N/A	**Date Created:** February 1, 2011

POLICY:

HCBS Waiver Direct Service Providers must acquire and maintain liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency.

PROCEDURE:

Upon request, the Direct Service Provider shall furnish a valid copy of the insurance policy to the Alabama Medicaid Agency or Operating Agency.

One or more copies of the certified liability insurance certificate must be displayed at each place of business at which the policy holder employs persons covered by the policy.

The Direct Service Provider is to retain all records related to the liability insurance policy.

Failure to comply with the HCBS Waiver requirements may result in recoupment of funds and/or contract termination.

REFERENCES:
HCBS Waiver Document

Approved: Marilyn Chappelle
Marilyn Chappelle
Director

Date: March 2, 2011