Centers for Medicare and Medicaid Services

STATE OF VERMONT
"CHOICES FOR CARE"
DEMONSTRATION WAIVER

OPERATIONAL PROTOCOL

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Section A: Organization & Structural Administration

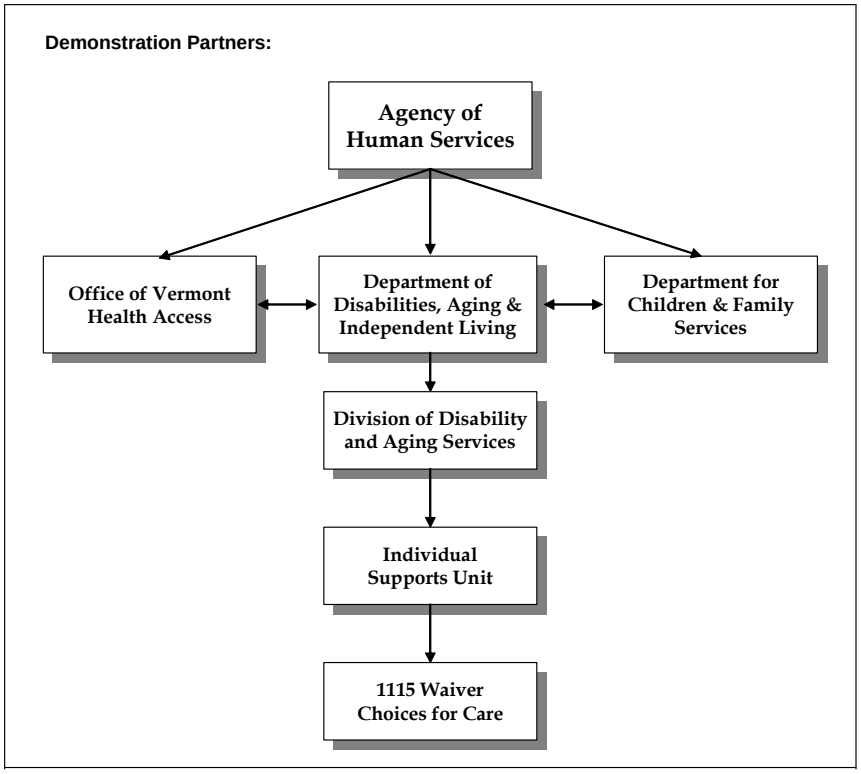
The State of Vermont has a well-regarded history of managing the state's publicly funded health care system to maximize the number of persons with health coverage while containing costs. In an effort to further improve its programs, the state developed this demonstration initiative to provide greater choice and the highest quality services possible to recipients in need of long-term care.

Through this demonstration the Vermont Agency of Human Services (AHS) will undertake broad based reform of the long-term care service system by offering a continuum of care that includes a series of options, including both home- and community-based alternatives and traditional nursing facility services. All persons eligible for Medicaid who meet the financial and clinical criteria for long-term care services in two of three clinical categories (Highest Need and High Need) will be enrolled in the demonstration program. Services will be provided on an entitlement basis to both those in the Highest Need group and in the High Need Group; however, those in the High Need group may have to wait to receive services until funds are available. In the interim, they may receive community Medicaid services, if they are eligible, and any other service for which they may qualify. [1] A waiting list will be developed if funds are not available to serve High Need individuals. Additionally, the state will expand eligibility to include individuals who meet the state's financial eligibility criteria and the clinical criteria for a new level of care – those with Moderate Needs. The Moderate Need group will have access to a limited array of home- and community-based services, subject to available program funding. A full description of the eligibility criteria and benefit package for each of the three clinical groups is included in later sections of this Operational Protocol.

The Department of Disabilities, Aging and Independent Living (DAIL) is the lead entity for this effort within AHS. Partners include the Office of Vermont Health Access (OVHA), the Department for Children and Families (DCF), and the range of local organizations and entities currently delivering long-term care services to Vermonters. These partners have been involved in the design and development of this project and will continue to take an active role as it is implemented.

Following is an organizational chart depicting the relationships among the various partners in the demonstration.

[1] *Current participants in the state's HCBS waivers and in Nursing Facilities are "grandfathered" into this demonstration. These individuals will continue to be served even if they are categorized as High Need versus Highest Need.*



Each partner has a specific role to play in the success of the demonstration. The Agency of Human Services is the single state agency for Medicaid in the State of Vermont and has overall responsibility for this program. AHS has the responsibility of issuing the 64 report. Office of Health Access is the state office responsible for the management of Medicaid and other publicly funded health insurance programs in Vermont. OVHA's mission is to ensure that Vermont's public health insurance system is efficient and effective as well as to collaborate with other entities to bring evidenced based best practice to the program. OVHA will be instrumental in assisting with cost avoidance. The Department of Children and Families, with their Economic Services Division, administers the Medicaid Program. DAIL will co-locate their LTCCC with the Long Term Care Eligibility specialist in DCF/ESD to ensure coordination and a responsive eligibility process. DCF/EDS makes the Medicaid financial eligibility determination and establishes the M900s, the financial rules for the Medicaid program. Division of Disability and Aging Services is the newly created Division within the Department of Disabilities, Aging and Independent Living. The Division includes the QA/QI unit, the Data Unit that will gather data for reporting purposes. The Demonstration sits in this Division. The Individual Supports Unit is the lead entity for the implementation of Choices for Care, housing the program manager, the Waiver Supervisors and the Long Term Care Clinical Coordinators. DAIL provides the LTC clinical determination and programmatic services.

The Department has identified eight functional areas necessary to support its core business operations for the demonstration. These units will have the primary responsibility for distinct operational processes necessary to administer the demonstration. The eight functional units within DAIL that are charged with the responsibility for administering this demonstration are:

- Clinical Services and Program Development
- Provider Network Development and Relations
- Quality Management and Improvement
- Research and Evaluation

- Enrollee and Family Services
- Utilization Management
- Financial Management
- Information Systems

The Long Term Care Clinical Coordinators will receive and process applications, determine clinical eligibility for Medicaid Waiver Services by screening initial applications for appropriateness and conducting an assessment of the individual to determine clinical eligibility; manage admissions to Medicaid Waiver services and authorize Medicaid Waiver Services for individual applicants and participants. Tasks will include reviewing individual assessments and service needs in the context of existing program policies and procedures, including variance requests to service volume guidelines. Based upon the level of need, develop a plan of care that will allow the individual to receive long term care services that meet individual needs and lead to positive individual outcomes.

The LTCCC will conduct options counseling to applicants, complete the wait list score sheet, maintain waitlist for High needs, conduct outreach and education, utilization review.

The LTCCC will manage Medicaid Waiver database by entering individual demographic data, eligibility information, and service information into a program database to assure accurate and current information regarding regional participants and approved services, and to facilitate measurement of participant outcomes.

An important role will be to facilitate regional Medicaid Waiver Team meetings. These teams are comprised of case managers and other providers in the LTC continuum and are responsible for overseeing the implementation of the care plans. By scheduling and facilitating meetings, including creation of meeting agendas and distribution of meeting minutes; mediating regional disagreements or disputes regarding eligibility or service authorizations; providing technical assistance in Medicaid Waiver and other home and community based services program policies and procedures to team members and other members of the regional community. They are also charged with assuring that regional long term care services are provided effectively and efficiently and report to DAIL as to what is working and what needs improvement.

LTCCC will be involved in training case managers and other regional staff in program policies and procedures including eligibility requirements, provider qualifications and service standards.

The Waiver Supervisors (2) will be responsible for supervising each six LTCCC. In this capacity they will provide oversight, guidance, policy interpretation, technical assistance, and training to the regional staff. They will also review the initial consumer appeals and make recommendations to the Waiver Manager for disposition. The supervisors will also participate in the development and implementation of the quality assurance program through participation in the Quality Assurance Unit. Maintaining provider relations through the development of provider agreements and development of provider training is also part of their roles.

The Waiver Manager is responsible for the overall implementation of Choices for Care. Policy development, policy interpretation and program guidance are the major responsibilities. The Waiver Manager will supervise the Waiver Supervisors providing guidance, technical assistance and direction. The Waiver Manager is responsible for fiscal monitoring to ensure that the program meets its fiscal goals and the operation is efficient and effective in its implementation.

Table 1 summarizes the tasks that are being completed to support the start-up and ongoing operations of the demonstration. The chart includes information on the expected dates of completion, status as an ongoing activity, and the organizational unit responsible for the task area.

Table 1: Tasks and Timeline

TASK	*COMPLETION DATE*	*ORGANIZATION/ UNIT*
Development of Policies and Procedures	July 2005	• Clinical Services & Program Development Unit/ Department of Disabilities, Aging and Independent Living • Department for Children and Families/Economic Services Division • Office of Vermont Health Access
Recruitment of Staff	July 2005	• Division of Disability and Aging Services/Dept of Disabilities, Aging and Independent Living
Training of Staff	July - September 2005 Monthly oversight and assistance during Year 1 Quarterly updates ongoing	• Division of Disability and Aging Service • Department of Children and Family Services/ Economic Services Division • Division of Licensing and Protection
Training Community Partners	July - September 2005 Quarterly review during Year 1 Semi-annual training Ongoing	• Division of Disability and Aging Service • Department for Children and Families/Economic Services Division • Division of Licensing and Protection
Marketing & Outreach	May 2005 and ongoing	• Division of Disability and Aging Services • Community Partners • Media
Member Education & Enrollment	September 2005 and ongoing	• Division of Disability and Aging Services/ Program Unit
Provider Development & Relations	August 2005	• Division of Disability and Aging Services/ Program Unit • Community Services Unit

TASK	*COMPLETION DATE*	*ORGANIZATION/ UNIT*
Utilization Review	Ongoing	• Division of Disability and Aging Services/ Utilization Review Unit • Department of Disabilities, Aging and Independent Living/ Long-Term Care Clinical Coordinators • Division of Licensing and Protection staff (as needed)
Quality Monitoring & Management	January, 2006 and ongoing	• Department of Disabilities, Aging and Independent Living/Long-Term Care Clinical Coordinators • Department of Disabilities, Aging and Independent Living -Utilization Review Staff • Division of Licensing and Protection staff • Department of Disabilities, Aging and Independent Living/QA/QI staff
Financial Management	Monthly	• Department of Disabilities, Aging and Independent Living/ Business Office Staff
Research & Evaluation	Year 2 and ongoing	Contractor – TBD
Information Systems	Monthly	• Department of Disabilities, Aging and Independent Living/ Information Systems Unit

Section B: Reporting Items

As required under the Special Terms and Conditions governing this demonstration, DAIL will provide comprehensive reporting to CMS on all aspects of the program. The plan for reporting on the demonstration is summarized below.

Monthly Progress Calls

During the first six months of operations, DAIL will hold monthly conference calls with CMS to discuss the demonstration's progress. This will include a discussion of any implementation and start-up issues that may arise, waiting lists statistics, the status of or results from evaluations and participant satisfaction surveys, service utilization, and quality assurance findings.. Thereafter, update calls will be held at a frequency determined by DAIL and CMS.

Quarterly & Annual Progress Reports

DAIL will submit quarterly progress reports to CMS within 60 days of the close of each quarter. The fourth quarter report each year shall include an overview of activities for the entire year and will serve as the annual progress report. The reports will include, at a minimum, the following information.

- a discussion of the events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures.
- a discussion of the state's progress in completing certain quality assurance and quality improvement plan activities
- a list of notable accomplishments
- a summary of any problems/issues encountered and how they were resolved
- waiting list statistics
- service utilization
- the status of or results from evaluations and participant satisfaction surveys,
- quality assurance findings

Final Demonstration & Evaluation Report

At the end of the demonstration period, a final draft report will be submitted to CMS for comments. DAIL will take CMS' comments into consideration and incorporate them into the final report. The final report will be submitted to CMS no later than 180 days after the termination of the project.

Financial Reporting

Form CMS-64 will be submitted quarterly within 30 days of the end of the quarter. This report will include total expenditures for services provided under the Medicaid program, including those provided through this demonstration.

Applicable rebates and expenditures subject to the budget neutrality cap will be reported on five separate Forms CMS-64.9 WAIVER and 64.9P WAIVER for each demonstration year, for each of the MEGs as follows:

- Form 1: Expenditures for the Highest Need group
- Form 2: Expenditures for the High Need group
- Form 3: Expenditures for the Moderate Need group
- Form 4: Expenditures for the demonstration eligibles who also receive CRT services
- Form 5: Expenditures for PACE Vermont participants

Cost settlements will be reported on line 10.b. Cost settlements not attributable to this demonstration will be reported on lines 9 or 10.c Cost settlements are made for outpatient hospitals and FQHCs/RHCs. All administrative costs for the demonstration will be reported on Forms CMS-64.10 WAIVER and/or 64.10P WAIVER.

Form CMS-37 will be filed quarterly with an estimate of the quarterly expenditures under the demonstration for both the Medical Assistance Program and Administrative Costs. The state will also file a supplement to Form CMS-37 which provided updated estimates of expenditures subject the budget neutrality cap.

Section C: Implementation of MMA Drug Benefit

The Department is working closely with a variety of state and community partners to ensure that a comprehensive information and outreach campaign successfully reaches Vermonters eligible for the Medicare Modernization Act (MMA) Part D drug benefit. The partners involved include OVHA, the Department of Children and Families/Economic Services Division, the Social Security Administration and the Vermont Area Agencies on Aging.

Training on the MMA benefit and eligibility criteria began in April 2005 through the State Health Insurance Assistance Program (SHIP) operated by the five Area Agencies on Aging. Several sessions will be offered to a wide audience beginning with "MMA 101" and will be continued through the initial implementation periods of the new drug benefit program. Sessions will be also be targeted to a wide range of local providers.

DAIL management and staff will also instruct case management supervisors in the elements of the program so that they can offer ongoing training to their line staff. The DAIL Long-Term Care Clinical Coordinators (LTCCCs) will take part in all types of training sessions offered. Informational meetings and training sessions will continue throughout the year.

Accordingly, both the LTCCCs and the local case managers will be well versed in the particulars of the MMA Part D prescription drug benefit program. As these staff interview potential applicants for the demonstration program, they will inquire as to the individual's status and eligibility for the Medicare Part D benefits. The referral form used for the program includes an indicator with respect to Medicare eligibility. Therefore, the staff will be aware of the person's eligibility for Part D. Individuals who are dually eligible for Medicaid will have "wraparound" pharmacy coverage through that program (see below).

The State of Vermont is also implementing changes to its pharmacy programs for dually eligible (Medicare and Medicaid) beneficiaries effective January 1, 2006 to incorporate the requirements of the Medicare Modernization Act. This includes the development of a program to pay the recipient's cost sharing obligations under Part D and to provide coverage for drugs in excluded categories under the Part D benefit (e.g., Benzodiazepines and Barbiturates). All beneficiaries served through this long-term care demonstration who have full Medicaid coverage in addition to Medicare will have "wraparound" pharmacy benefits provided through the Vermont Medicaid program. Local case managers and the LTCCCs will provide participant education on the Part D program and the Medicaid wraparound drug benefits.

The Agency of Human Services, the Single State Agency for Medicaid in Vermont, is now updating its reporting requirements to accommodate the changes brought about by the Medicare Modernization Act. These requirements will continue to be modified as necessary in CY2006 and beyond to reflect the Vermont Medicaid program's role as the secondary and supplemental payor to Medicare's Part D program for the dually eligible population. These financial and reporting changes will be incorporated into the reporting requirements for the 1115 LTC demonstration waiver.

Section D: Reporting on LTC Demonstration Participants who are Receiving Community Rehabilitation & Treatment Services

Individuals who meet the clinical criteria for the long-term care demonstration and are enrolled in that program may also receive Community Rehabilitation and Treatment (CRT) services if they have severe and persistent mental illness and qualify for services under the state's CRT waiver program. These individuals will be dually enrolled in both the long-term care demonstration and the CRT program.[2]

Vermont will implement a tracking and reporting system that separately identifies any expenditures for CRT services provided to participants enrolled in the long-term care demonstration. CRT recipients will be identified on the "other insurance panel" which indicates that they have CRT coverage. This will trigger the 64 CRT sheet. A subset will be extracted based upon service received based upon the MARS category codes. The CRT LTC waiver services expenditures will report on the LTC CRT sheet. Expenditures for all other services provided to such individuals will not be reported under the LTC demonstration. They will continue to be accounted for through that waiver's distinct budget neutrality limit.

A separate CMS-64.9 form will be filed quarterly for the CRT Medicaid Eligibility Group (MEG). This will include individuals who are enrolled in the long-term care demonstration, but who are also receiving CRT services.

[2] *The CRT waiver program is operated under the auspices of the VHAP Section 1115 demonstration waiver.*

Section E: Reporting on Participants who would be Included in PACE Vermont

Overview

From the beginning, PACE programs have collected data about their enrollees in order to more effectively serve PACE participants and demonstrate the effectiveness of the model of care. Utilization and Census information for PACE Vermont will be collected through DataPACE. DataPACE is a comprehensive data collection program that provides resources for data collection, report management and data correction. Data are collected in the following areas: enrollment/disenrollment; health; functional status assessment; service utilization; inpatient utilization; and informal supports.

Data are used for the following purposes:

- to prepare reports on participant characteristics for the Centers for Medicare and Medicaid Services, state Medicaid agencies, researchers and others
- to enable PACE programs to engage in cross-site data analyses and benchmarking and to monitor the progress of the model as it matures

The National PACE Association uses the DataPACE data to create the PACE Profile as well as provide cross-site comparisons for organizations to benchmark their data. PACE Vermont will enroll in the DataPACE program. PACE Vermont will agree to provide resources for data collection, report management, and other matters pertaining to the integrity of the PACE Minimum Dataset. The National PACE Association will agree to provide software, manuals, technical support and continued training. Data are monitored by the National PACE Association for quality and completeness.

PACE Vermont Program Development & Implementation Plan

PACE Vermont was incorporated as a Vermont domestic non-profit corporation in December 2003 and is the result of two long-term care coalitions joining forces to create a collaborative approach to governing and administering two PACE Centers under one PACE program to serve frail elderly Vermonters. The new Coalition includes the Champlain Long-Term Care Coalition (which serves Chittenden and Southern Grand Isle Counties) and the Rutland Long-Term Care Coalition (which serves Rutland County). The coalition has active representatives from key organizations providing senior housing, home care and hospice services, skilled nursing care, inpatient and outpatient hospital services (a tertiary academic medical center in Chittenden County and a large community hospital in Rutland County), senior center services, transportation, mental health care, vocational rehabilitation, adult day programs, AAA services, and physician services. Other community representatives also participate in the coalition.

The partners in the two coalitions have elected a transitional Board of Directors for the new corporation that will serve for two years. This will enable the PACE staff and program to capitalize on the expertise and in-kind support services of the partners in several areas. For example, Fletcher Allen Health Care will provide claims processing and accounting functions through their managed care company, while the Rutland Visiting Nurses Association will provide marketing support. All partners within the Coalitions will be key in promoting the PACE philosophy and in identifying

potential participants. The time and expertise provided by all of the partners serving on committees and task forces have furthered, and will continue to further, the achievement of program goals during the development and start-up period. PACE Vermont anticipates subcontracting for other services from other coalition organizations. These subcontracting arrangements will be completed prior to submission of the PACE Application.

In summary, the partners in the two coalitions have extensive experience and have a demonstrated commitment to improving services for frail older adults. With their leadership and expertise in working with this population, and with the state and federal Medicaid and Medicare reimbursement and regulatory systems, PACE Vermont anticipates being able to enroll over 60 participants in each location within the first three years and expects to enroll over 120 participants in each location within five to seven years. In order to reach persons in the state's most remote areas the program will invest in transportation and technology linkages for the PACE program.

Application Process

Vermont has previously submitted a state Plan Amendment to CMS and received approval to offer PACE as a service. In 2004, the Vermont General Assembly appropriated $100,000 in start up funds for PACE Vermont. PACE Vermont has also received $20,000 from the Vermont Community Foundations, $80,000 from the James T Bowse Community Health Trust grant, and is pursing other private foundations for additional funding. In addition, $744,000 was earmarked in legislation for the program by Senator Jeffords.

PACE Vermont is working with the state and Palmetto Health to finalize its application and will submit it to CMS in the summer of 2005. It is anticipated that the readiness review will be conducted by the Department of Disabilities, Aging and Independent Living in the spring of 2006. The first participants will be enrolled in July 2006. CMS is expected to conduct a site visit in the summer of 2006.

The application will provide a detailed description of the plan for implementing the PACE program in Vermont. The implementation plan will cover the following items:

- General Information & Organization
- PACE Administration
- Financial Information
- Marketing Plan
- PACE Services
- Participants' Rights
- Quality Assessment & Performance Improvement
- Participant Enrollment & Disenrollment
- Payment Processes
- Data Collection, Record Maintenance & Reporting
- Program Expenditures Reporting

Fiscal Monitoring

Financial information will be maintained by PACE Vermont. The financial records and reports of PACE Vermont will be prepared on a monthly basis using the accrual basis of accounting and

conform to GAAP and industry standards. These records and reports will be an accurate reflection of all financial transactions occurring during the reporting period. An independent public accounting firm will audit the financial statements of PACE Vermont on an annual basis. A letter of their findings and recommendations will be issued along with an annual report of financial condition. The annual financial statement will contain a statement of operations, balance sheet, changes in fund balance, and a statement of cash flow. PACE Vermont will submit quarterly financial reports to the state documenting actual expenditures.

A separate Medicaid Eligibility Group (MEG) will be used to track and report expenditures under the demonstration for individuals enrolled in PACE Vermont.

In addition, as part of the cost analysis, actual utilization of services will be monitored. Utilization information will be gathered through DataPACE. This will include census; percentage of enrollees needing help with ADLs; and utilization of inpatient services, outpatient services, day center services, physician services, nurse practitioner, nursing, PT, OT, recreational therapy, social work, personal care, and overnight support. This information will be compared with census and utilization data from other individuals receiving home- and community-based services under the demonstration. In addition, this information will be compared with PACE sites in other states.

Section F: Outreach/Marketing/Education

Prior to the implementation of the demonstration an extensive marketing campaign will be established. That campaign will focus on communicating with individuals currently enrolled in the HCBS programs, existing providers, referral sources and state staff involved in the demonstration. An initial campaign began with a Vermont Interactive Television (VIT) session in April 2005 to review the anticipated time frame for start-up, how the new demonstration program will affect current enrollees; and highlighting changes in eligibility, program benefits, enrollment processes, the delivery of services and the transition from the current 1915(c) HCBS waiver programs. The Department will continue the monthly informational sessions via VIT throughout the implementation stages of the demonstration.

Prior to start-up, a letter will be sent to each participant describing the new program and what effect, if any, it will have on his or her current service plan. In addition, case managers will inform current enrollees of program changes at the time of their monthly contact. The direct contact will permit the accommodation of persons with special needs and those with Limited English Proficiency (LEP). Both interpreter services and bi-lingual materials will be provided within this demonstration on the same basis as is done through the Vermont Health Access Plan Demonstration for persons with LEP. Interpreters are available for individuals who have language barriers. The current process requires a referral to the Vermont Interpreters Referral Services that includes specific details of time, place and location. Interpreters from the Referral Service must be listed on the contract with the Department of Disability and Independent Living.

The Agency for Human Services' policy and protocol for Limited English Proficiency, including interpretive services on file. See Attachment U.

Brochures, fact sheets and press releases will be the basis of a broad effort to dispense general information. Senior Help Line and the 211 information and assistance line will be utilized as a method for interested individuals to obtain additional information on the new program. The DAIL website also includes information on the demonstration program. Attachment A to this protocol includes "mock ups" of the informational brochure and other materials developed to date.

LTCCC will have the responsibility for conducting outreach to the local community partners, including hospital discharge planners, physician offices, nursing facility admission/discharge staff, residential communities, local advocacy groups, and case managers from the Area Agencies on Aging and Home Health Agencies. LTCCC will attend local waiver team meetings and other community events to ensure ongoing communication as the program is implemented.

A significant effort will be made to ensure that the discharge planning staff at local hospitals and the admission staff at nursing facilities have a complete understanding of the changes in the Medicaid long-term care service system. LTCCC will develop a close working relationship with these partners by attending staff meetings, providing case consultation on referrals, and encouraging the attendance of these individuals at local waiver team meetings.

A comprehensive training packet will be used for the in-depth training of state staff, community partners and referral sources. An outline of this training program is included as Attachment B.

The training curriculum is constructed in three modules. The topic areas are similar; the depth of the content is specific to the audience. The three target audiences are as follows:

- state intake and eligibility staff, case managers and service providers
- associated community partners and referral sources
- the larger community

Each training packet addresses the scope and depth of information required by each of these three groups to understand the new demonstration program and its parameters.

The general public and potential enrollees will be informed through the media campaign, contact with informed community partners and the availability of informational brochures placed in doctors offices, pharmacies, senior centers, congregate meal sites, and housing facilities.

After the initial, intensive training of state staff, case mangers and service providers, ongoing update training will be offered no less than annually. These sessions will be either a review of the program and its operations or an update on program and policy changes, as necessary.

Specific training will be offered to case mangers and providers regarding the Moderate Needs group with respect to eligibility criteria, service provision and coordination, and reporting under the demonstration.

The Cash and Counseling Program is still in the developmental stages. Plans for information dissemination and training are yet to be developed. It is anticipated that as this program is ready to be incorporated into the demonstration program-specific marketing and educational materials will be developed and outreach strategies to promote this program will be implemented.

Funding from a Robert Wood Johnson Foundation grant, which is supporting the Cash and Counseling Program, has been utilized to hire a fulltime Program manager. Polices and procedures, information dissemination, training and the development of the support systems necessary for implementation of the Cash and Counseling Program are anticipated to be completed by December 2005. The enrollment phase is projected to begin in January 2006. Based on current home and community waiver data supporting consumer/surrogate directed options, it is projected 50 individuals will be enrolled within the first year. It is anticipated 250 individuals will be enrolled in the Cash and Counseling Program by the end of the third year.

Publicity for the Cash and Counseling program has already begun with the project director's meeting with provider and consumer groups around the state to discuss the program. Based on the experience of the Cash and Counseling demonstration states, Vermont plans a targeted rather than broad based information campaign before the program begins. This will include a mailing to all LTCM recipients describing the program and how to enroll. Current case managers will be educated through mailings and face-to-face training. A significant portion of a VIT session in the late fall will be dedicated to the program. On an ongoing basis, the Long Term Care Clinical Coordinators will discuss the Cash and Counseling option with each recipient as they enroll in LTCM and it will be re-addressed as an option at reassessment. Consumers will self-select for the Cash and Counseling program using a to-be-developed self-screening tool. Any written or other formal media developed for community and consumer education will be cleared with CMS staff.

Cash and Counseling will be piloted state-wide but to a limited number of enrollees, currently slated at 50 recipients. These will be selected on a first-come/first-served basis. As the program processes become established, the number of enrollees will expand, again on a first-come/first served basis. The program projects 200 enrollees from the 1115 population by the end of the grant period in 2008.

Section G: Notification of Program Participants

Current participants in the 1915(c) waiver programs will receive written notification 30 days prior to the implementation of the demonstration of the changes in the home- and community-based services programs. All participants in the existing HCBS waiver programs and those residing in nursing facilities will be automatically enrolled into the demonstration program. The notice sent to inform them about the new program will also tell them that they are being automatically enrolled in the demonstration and that no action is required of them at that time. The notice will also tell them whom to call if they have any questions. It will further instruct them to contact their case manager if they have any concerns about their continued provision of services. The notice will include a general description of the new demonstration program. It will highlight the differences between the existing programs and the new program, describe how these changes may or may not affect them, and provide information on who they can contact for further information. A copy of the notification letter is included as Attachment C.

Notices will also be sent to individuals who are resident in a nursing facility. That notice will inform them that they may continue to receive services in the nursing facility under the new demonstration. All participants residing in nursing facilities will be automatically enrolled in the demonstration program. The notice sent to inform them about the new program will also tell them that they are being automatically enrolled in the demonstration and that no action is required of them at that time. The notice will also tell them whom to call if they have any questions. They, or their family members or legal representatives, may also contact the LTCCC with any questions they have, including requests for an evaluation to determine if they might be able to return to the community with home- and community-based support services. When the auto-enrolled demonstration participants have their next re-assessment, their clinical eligibility status will be re-determined and they will be assigned to the appropriate clinical category (Highest Need, High Need or Moderate Need group) under the demonstration.

All Home and Community –Based participants are re-assessed annually. The LTCCC reviews the new assessment information for level of care. If the HCBS participant meets the Highest or High needs criteria they will continue to receive waiver services. If they do not meet Highest or high needs criteria, the LTCCC will review the participants' level of care using the 1915c level of care guidelines. Nursing facility participants are re-assessed quarterly by DLP using the MDS for level of care. If there is a drop in their RUGS category score, DLP will notify the LTCCC who will then go out and re-assess the participant based upon the level of care guidelines from the 1915c program.

Eligibility Determination Process

Elderly persons and younger adults with physical disabilities who meet the clinical and financial eligibility requirements of the LTC Medicaid program will be enrolled in the demonstration. At the time existing participants in the state's current HCBS waiver programs are auto-enrolled into the demonstration program, enrollment in the 1915(c) programs will cease. Individuals who were eligible under the previous 1915(c) waivers or those who are residing in a nursing facility will be automatically enrolled in the demonstration and will continue to receive the services on their current plan of care. When these auto-enrolled individuals have their next re-assessment their clinical eligibility for the demonstration will continue provided that they meet the clinical criteria for the Highest or High Need groups. This will be the case regardless of the level of funding available for the High Need group.

New applicants will be enrolled in the demonstration if they meet the clinical criteria for the Highest Need group and also meet the financial eligibility requirements for the LTC Medicaid program. If pre-demonstration participants do not meet Highest or High Need at their next assessment, they will be assessed using pre-demonstration criteria to determine their continued eligibility. New applicants who do not meet the clinical criteria for the Highest Need group but do meet the criteria for the High Needs group (and are otherwise financially eligible) will be enrolled and served through the demonstration to the extent that funding is available.

Moderate Need group applicants must meet the clinical criteria for that group, as well as the financial criteria established for this demonstration program. DAIL has established the following financial criteria for the Moderate Need group:

- Income at or below 300 percent of SSI (includes all sources of income)[3]
- Resources of less than $10,000.

Individuals applying for Moderate Group service will be complete an application. Upon receipt of that application, the provider of service will complete an abbreviated ILA assessment. In that assessment, an individual will respond as to their Medicaid status. They will complete clinical and financial application. Individuals who are Medicaid eligible will receive priority in the receipt of service. If the Moderate Needs group has a waiting list, that waiting list has an indication as to the individuals Medicaid status. Providers are instructed and it is stipulated in regulation, that individuals who are categorically eligible for traditional Medicaid shall receive priority access to the Moderate Needs group. The waiting list will be sent to the LTCCC monthly, who will track applicants and their status. When an application is received to add an individual to the Moderate Group service, the LTCCC will check the wait list to determine if the individual is on the wait list, is Medicaid eligible and, if not, there are no other Medicaid eligible persons on the list.

[3] *Monthly medical expenses (including but not limited to prescription and non-prescription medication, physician, hospital or other medical provider bills, health insurance premiums, copayment or deductible costs paid by the individual, and medical equipment and supplies) are deducted from the individual's gross monthly income to determine their adjusted income for purposes of determining eligibility as a Moderated Need enrollee under this demonstration.*

Individuals who meet the Moderate Need group clinical criteria will be identified by local demonstration network providers, including Adult Day, Homemaker, and HASS providers. These providers will also manage the enrollment process for this group by screening for clinical and financial eligibility. The providers will then arrange for the provision of any of the three covered services for this group that are deemed appropriate and necessary. DAIL will ensure the provision of case management services for the Moderate Needs group. The participants who are receiving HASS services will be case managed by the HASS Service Coordinators. There may be Moderate Needs individuals placed on a waiting list due to a shortage of funding. These waiting lists will be coordinated by the local providers and they will be administered on a first-come, first-served basis. Copies of any waiting list will be provided to DAIL, which will maintain a consolidated list by region.

A detailed description of the clinical and financial eligibility criteria, assessment and re-assessment procedures, and level of care determination processes applicable to this demonstration are included in Attachment D.

Resource Limits

Under the demonstration the resource limit for single individuals in the Highest and High Need Groups who own and reside in their own homes will begin at $3,000 (in addition to the existing $2,000, totaling $5,000) and raised in phases up to $10,000 provided funding is available. This will permit individuals to maintain adequate assets to ensure they are able to make any home repairs necessary to allow them to safely remain in their home (e.g., a working furnace, a leak-proof roof, etc.).

Determining Level of Care & the Intake, Assessment & Enrollment Process

For the Highest and High Need group members, LTCCC will receive referrals from multiple sources in the community. (Attachment E includes the referral form). Current assessments, if they exist, will accompany the referral. This will include existing long-term care service assessments, nursing home admission assessments, residential care home assessments, and/or hospital admission assessments. The determination of clinical eligibility will be based upon the referral, assessment, and any other available information. If the information needed to make a determination of clinical eligibility is not readily available, LTCCC will contact the applicant or their representative to obtain more information and complete a clinical assessment. A face-to-face interview will be conducted, if necessary. If the individual is found clinically eligible, a clinical certification form is sent to the Department for Children and Families/Economic Services Division for a determination of financial eligibility. If the individual is found clinically ineligible, a denial notice with a description of appeal rights is sent to the applicant.

If the case manager and the home-based or Enhanced Residential Care provider believe that the applicant meets the long-term care Medicaid financial eligibility criteria, services may begin immediately after the DAIL clinical certification is made. While the financial eligibility determination is pending, LTCCC will determine the minimum level of services necessary to maintain the applicant at home. The decision to start services prior to the financial eligibility determination will be made between the provider of service and the applicant. Any services provided during this interim period will be in accordance with an agreement between the provider and the individual or his/her legal

representative. The provider may not bill the Medicaid program for long-term care Medicaid services until the Department for Children and Families/Economic Services Division has determined that the individual is financially eligible and DAIL has authorized the Service Plan. If the individual is ultimately found ineligible for long-term care Medicaid services, DCF staff will notify DAIL, the participant, and the highest provider of service (if patient share due). The provider may bill the individual for any services provided from the date of clinical certification through the date a denial notice was received by the provider.

If the individual elects to receive his/her long-term care services in a nursing facility and the facility believes that the individual will meet the long-term care Medicaid financial eligibility criteria, the facility may start delivering services immediately after LTCCC provides a clinical certification. The nursing facility provider will inform the individual that admission prior to the final financial eligibility determination may result in a personal financial liability if they are subsequently found ineligible for long-term care Medicaid program.

DAIL protocols document the process and parameters for making clinical and financial determinations for each of the three clinical groups (Highest, High and Moderate Needs). These documents are included as Attachment D. The LTCCC will be responsible for making clinical and level of care determinations. In cases that are unclear, LTCCC may also consult with the staff of the Division of Licensing and Protection.

Individuals with an active mental health status or developmental disability who elect to utilize nursing facility care for their long-term care needs will initially be screened using the Preadmission Screening and Resident Review (PASARR) instrument. If the PASARR screen results in a determination that the individual may need active mental health treatment, the screener will contact the Department of Health/ Division of Mental Health for assistance with further evaluation of the individual.

Once an individual is determined to be clinically eligible for the program, a Long-Term Care Clinical Coordinator (LTCCC) will make a determination as to whether the individual meets the Highest or High Need group criteria. The LTCCC will discuss long-term care Medicaid service options with the individual as part of the application/assessment process. Individuals may also request additional options information and education by marking that request on their referral form. The LTCCC will assure that options brochures and educational information are available as needed.

As previously discussed, clinical eligibility for the Moderate Needs group is determined at the local provider level based on DAIL criteria.

If the individual is found to meet all of the clinical eligibility criteria, the LTCCC will forward the Clinical Certification Notice (see Attachment F) to the case management agency that the individual selected on the initial referral form. The local case manager will contact the individual and make arrangements for the completion of the Independent Living Assessment. A registered nurse will complete the health assessment portion of the ILA. The case manager will assess the individual's circumstances, resources, program eligibility, and formal and informal support systems. The results of the assessment will serve as the basis for the development of the individual's plan of care. The case manager will conduct a review of service options and discuss any limitations with the individual or their representative. The case manager will, in conjunction with the individual or his/her

representative, develop a comprehensive service plan that addresses his/her needs. The participant will review and sign-off on the service plan. The completed assessment and signed service plan will be sent to DAIL for a staff level review. LTCCC will conduct a thorough utilization review prior to authorizing a new annual service plan. If the individual chooses a nursing facility as their long-term care setting the case manager will assist them in locating a facility, if necessary.

The case manager may also assist the participant in completing any financial eligibility reviews that DCF requires to maintain long-term care Medicaid eligibility if such assistance is requested.

The ILA measures cognitive status as well as functional status. The ILA also assesses mental health status and will provide the case manager with the information needed to develop a care plan to address these needs as well.

Annual Re-Assessments

Participants will have a comprehensive assessment completed on a regular basis. The reassessment procedure is determined by the particular long-term care Medicaid setting in which the individual is served.

For those receiving home-based services, the case manager will complete a re-assessment of the individual using the ILA at least annually and prior to the anniversary of the participant's admission into the program. The case manager will assess any changes in the individual's circumstances, resources, program eligibility, and formal and informal support systems since the time of the original assessment or last re-assessment. If needed, an RN will complete a re-assessment of the individual's health condition.

The case manager will also conduct a review of any new or more appropriate service options that should be considered with the individual or their representative. The case manager will modify the comprehensive service plan, as appropriate, in conjunction with the individual or their representative. The participant will review and sign-off on the revised service plan. The completed re-assessment and signed service plan will be sent to DAIL for a staff level review. LTCCC will conduct a thorough utilization review prior to authorizing any modifications to the annual service plan.

For participants residing in an Enhanced Residential Care (ERC) facility, the residential home care provider will complete a comprehensive reassessment or RCHRAT (see Attachment G). Annually, prior to the end of the current annual plan of care, a registered nurse must complete a reassessment. The ERC provider will send a copy of the RCHRAT to the participant's case manager. The case manager will complete an ERC tier worksheet and ERC service plan. The participant will sign the revised service plan and the case manager will submit the completed re-assessment packet to the LTCCC for utilization review and acceptance.

For individuals residing in nursing facilities, the nursing facility provider will continue to complete the Minimum Data Set or MDS according to current federal and state nursing facility regulations.

Re-assessments are required annually for home-based settings, at a minimum, and prior to the anniversary of the participant's enrollment. Re-assessments are also conducted when there is a

significant change in the individual's condition, as identified by the participant, case manager, a Long-Term Care Clinical Coordinator, or for any other reason identified by the LTCCC. Individuals who reside in nursing facilities will be re-assessed when triggered during the utilization process.

Disenrollment

An individual may voluntarily withdraw from participation in the long-term care Medicaid program at any time for any reason. The individual will inform the case manager or provider of their decision to withdraw. A change report form will be completed by the case manager or provider and submitted to DAIL and DCF indicating the reason for termination and that it is voluntary.

Applicants may be denied eligibility and active participants may be terminated from the long-term care Medicaid program for any of the following reasons: clinical ineligibility, financial ineligibility, death, permanent move out of state, or a temporary out-of-state move that exceeds 30 continuous days, or in circumstances in which DAIL is not able to assure the individual's health and welfare. A Change Report form (see Attachment H) must be submitted to DAIL as notification of participant termination in all cases.

Determining Existence & Scope of Applicant's Third-Party Liability

The existence of third-party liability will be determined as part of the financial eligibility processes for those in the highest and high needs group. At the time of application for long-term care Medicaid, an applicant is required to provide information about any other private health insurance. The Department for Children and Families/Economic Services division obtains the name, address, group and policy number, type of coverage and names of persons covered. If an applicant fails to disclose this information Medicaid will be denied.

Implementing Consumer-Directed Services

Vermont has had a long history of utilizing consumer- directed services.
Currently, 45 percent of participants are receiving consumer or surrogate-directed services throughout the state. The state anticipates that this will continue to be a popular option under the demonstration.

Case mangers are trained in the nuances of consumer and surrogate-directed services and are competent in assisting participants in operationalizing this option. A consumer and surrogate-directed services employer handbook has been developed which offers detailed guidance on the roles and responsibilities of an employer. (See Attachment I).

Under the demonstration, the consumer and surrogate-directed services option is available statewide. Over the course of the five-year demonstration period the state anticipates that the use of this option will be expanded by approximately 65 percent. See Section M of this document for more information on the consumer and surrogate-directed option.

Allocating Cash Allotment to Participants for Self-Directed Services

Individuals who choose to enroll in the self-directed Cash & Counseling will receive an independent functional and clinical assessment. The state will use the assessment to determine the cash value available to the individual. After establishing the cash value for the plan, the individual will then be able to choose a consultant. The consultant will work with the individual to develop an individualized spending plan. The program plans to allow the distribution of cash to consumers for items or services that cannot be easily invoiced.

Section I: Enrollment Limit

Current participants in the 1915c Waiver will be automatically enrolled into the Choices for Care program and will continue to meet LTC clinical eligibility for HCBS or nursing facility services using pre-demonstration assessment criteria. Subsequent assessments will be conducted using the Choices for Care assessment tool.

New applicants who meet the clinical criteria for the Highest Need group and the financial eligibility standards for LTC Medicaid will also be similarly enrolled and served through the demonstration. However, for new applicants who meet the clinical criteria for the High Need group and the financial criteria for LTC Medicaid, services will be started if funding is available. These individuals may be placed on a waiting list for services if adequate state and federal funds are not available at the time of their eligibility determination.

Waiting lists need to be maintained by region in order to assure that the smaller, less densely populated areas of the state are provided the opportunity to participate on a level playing field. The rationale for this method is to ensure that the availability of access to the program is equitable across the state. If one list were maintained based upon priority score alone, the more densely populated areas would, by pure volume, have access to High Need "slots" and the more rural areas would not have an opportunity to be served. As in our current program, we will utilize a formula for the distribution of "slots" for the High Needs group. That formula takes into account the number of applicants on the waiting lists within each area of the state, the number of applicants in a region as compared to the state, and a formula of "fair share" or equitable demographic allocation of slots.

The waiting lists for each area of the state will be maintained by each of the local DAIL Long-Term Care Clinical Coordinators (LTCCCs), and managed in conjunction with the local waiver teams. A wait list sheet will be used when there is a need for a waiting list for services for individuals who meet the High Needs clinical criteria, but for whom no funding is available. The protocol and priority score sheet is included as Attachment J to this protocol. Individuals will be scored using the High Need wait list tool which identifies their status by category. Based upon the individual's score, his/her priority position on the list will be determined. Enrollment into the demonstration and the provision of services will begin in order of priority category as well as other considerations.

If funds are not available at time of referral, LTCCC will complete a High Needs Wait List Score Sheet. A score will be generated based on the individuals Activities of Daily Living (ADL), Cognition, Behavior, Medical Conditions/treatments and Risk Factors. The LTCCC will then place the individual on a waiting list in order of score. LTCCC will notify the individual in writing, including information on other non-long term care Medicaid resources and inform them of their appeal rights. LTCCC will forward a copy of the Referral Form and Wait List Score Sheet to the Case Management agency indicated on the Referral Form. The case manager will contact individuals on the "High Needs " wait list on a monthly basis by phone for the purpose of determining if they have had a change in their health or functional needs. Based upon the information gathered during this contact, the case manager will conduct a new assessment if it is determined that changes may have occurred, for example, frequent falls, increased frailty, etc. If the individual has had a significant health or functional status change the case manager will contact LTCCC or reassess and submit to DAIL for clinical eligibility determination and/rescore for wait list. If the

assessment tool captures a change status in the range of 3-4 for ADLs, the absence of 3-4 score on the High Need Wait List Score Sheet is a trigger that the individual meets Highest Need.

The waiting lists will be reviewed monthly at the waiver teams' regular meetings. Case Managers will be charged with maintaining contact on a monthly basis with individuals on the waiting list to inform them of their status.

Monthly financial monitoring will be done on expenditures, as is the current practice. As the financial picture indicates funds available to add high needs individuals to the program, an analysis will be done taking into account "fair share" of service among the regions and the percentage each region has of the total wait list statewide and other factors. Additional " slots" will be given to particular regions based upon this formula to add High Need persons to the program. This is the same practice as today.

Slot availability will be determined by examining current expenditures, the average cost of Plans of Care, point in time projections in the reduction in the number of nursing home bed days and expenditures, and inflation or "creep factor" for home based and ERC expenditures

When funds are available, DAIL staff will notify the LTCCC. The LTCCC together with the Waiver Team will review the waiting list. Decisions will be made in order of priority and in consideration of other pertinent factors.

Moderate needs individuals will be served to the extent funding is available for this group. These individuals are only eligible for a limited package of home- and community-based services. Waiting lists will be maintained at the local provider level if there are not adequate funds to serve everyone who meets the clinical and financial eligibility criteria for the Moderate Needs group. Individuals with Community Medicaid will have priority. Otherwise waiting lists will be administered on a first-come, first-served basis. See Section K for more information on the benefit package for this group.

There are no pre-set limits on enrollment. Vermont fully intends to serve more people in need under this demonstration than was previously the case. However, funding constraints may result in some persons with lesser needs having to wait for funding to become available before they can be served. Applicants for Choices for Care services may apply for Medicaid and receive State plan services, if eligible, while waiting for long-term care services.

Waiting Lists

At the beginning of the program (October 1,2005) we anticipate that all individuals currently on the waiting list for the 1915c waiver will make an application for the Choices for Care program. Individuals who are Highest Need will be enrolled into the program, if financially eligible. Individuals who are High need will be prioritized, if funding is not immediately available to provide services. Once financial information is available, 6-9 months into the program year, an assessment of funding will be made and a determination of expenditures against projections will determine if there are funds available to begin serving the High Needs population. A plan will be developed based upon a range of factors including elements of the wait list, as described above.

With respect to the Moderate Group, they will only be served within the set aside funds of $1.7 million. As the Moderate Group is the demonstration group in this program, they will remain distinct. A

member of the Moderate Group may, however, move into the High or Highest Category if their needs change accordingly. Any saving from serving the Highest Need group will be used to serve individuals on the High Need wait list.

There are two separate and distinct waiting lists: one for High Needs individuals and one for Moderate Needs individuals. There is no waiting list for the Highest Need. Because the Moderate Group is the demonstration group they are being served by a separate and finite pot of money (1.7 million). By virtue of that scenario, they will be served before individuals who have High Needs and on a waiting list.

Cash and Counseling

Cash and Counseling is currently scheduled to begin operation in January 2006. The current working timeline for implementation is in Attachment S. The project director is actively involved in identifying support brokers and financial agents for the program. Vermont will identify at least one organization, which will serve as the support broker (or "counselor") for Cash and Counseling. If the consumer is new to home-based LTCM services, the counselor will complete a needs-assessment using the process currently in place across the home-based LTCM services. From this assessment, the counselor will develop a plan of care using the list of approved services for the traditional home based care option in LTCM. These services will then be converted into a cash equivalent using current Medicaid reimbursement rates. That cash equivalent will then be discounted to reflect the difference between scheduled and received services in the traditional home-based program. That exact discounting figure will be calculated by comparing the planned and billed services for a sample of recipients currently receiving LTCM services.

After the cash equivalent has been determined, the counselor will engage in a person-centered planning process with the consumer. The outcome of this will be a new plan of care or budget for the consumer. Counselors will receive training in person-centered planning as well as become well versed in the specifics of acceptable uses of the money available to the consumer. If needs are not clearly within the range of acceptable uses, the counselor will seek approval from the DAIL staff before agreeing to the budget. DAIL staff will initially review all Cash and Counseling budgets.

Vermont currently has a financial agent for its consumer-directed programs and the Cash and Counseling project director is working with them to determine whether they can work with the Cash and Counseling population. In any event, consumers will work with a Financial/Employer Agent to assist with payroll and the purchase of other goods and services that are developed via the person-centered planning process.

The specifics of how a consumer's budget is spent can be changed on-demand by the consumer, either as they resolve a set of care needs or as their personal priorities change. These changes will, however, need to be negotiated with the counselor. Changes in the amount available to consumers may occur as the consumer's acuity changes over the course of time. All consumers will be formally reassessed annually.

Section J: Restricting Providers

This portion of the demonstration design relates to the state's process for contracting for nursing facility bed days. Selective contracting for nursing facility bed days under the demonstration is on hold at this time. Should the state decide to implement selective contracting for nursing facility bed days in the future, DAIL will develop a process and criteria for selecting the nursing facilities and an allocation method for Medicaid reimbursement, all of which will be subject to CMS review and approval. The criteria used for any selective contracting process will be consistent with the requirements of Section 1923 of the Social Security Act and with respect to access, quality, and efficient and economic provision of care and services.

Should the state decide to move forward with selective contracting, DAIL will also submit to CMS, for its review and approval, provider contracts, any legislative provisions governing the selective contracting process, as well as a description of the public notice process.

In the interim, Vermont will continue its current process for contracting with nursing facilities for bed days.

Description of Amount, Duration & Scope of Services for Each Demonstration Group & Interface with Other Services

Individuals found eligible for full Medicaid benefits will have access to all Medicaid covered acute care services in the same manner as they do under the current program. This section of the Operational Protocol describes the long-term care benefits available to demonstration participants.

Services are available in the home- and community-based and institutional (nursing facility) setting for individuals in the Highest and High Need groups. Home-based services include case management, personal care, adult day care, respite care, companion services, personal emergency response systems and assistive devices and home modifications.

Services provided to individuals in Enhanced Residential Care (ERC) settings are bundled into a daily rate for the facility. The services provided in the ERC setting include case management, nursing overview, personal care services, medication management, social and recreational activities, 24-hour supervision, laundry, and housekeeping services.

For individuals served in a Nursing Facility setting the services include 24-hour skilled nursing, specialized rehabilitation therapy, personal care, medication management, meals, social and recreational activities, 24-hour supervision, laundry, housekeeping, nutritional services and social services. These services are reimbursed through a bundled daily payment to the nursing facility.

Persons who meet the clinical criteria for the Moderate Needs Group will be eligible for case management, adult day care and homemaker services only. The actual level of services provided will be dependent on the funding available for this group.

There are two types of Personal Care Service providers; both types of providers render assistance with Activities of Daily Living (ADLs) such as eating, medication management, dressing, walking, transferring, toileting and bathing. Instrumental Activities of Daily Living (IADLs) such as cooking, cleaning, and shopping assistance may also be provided. Services may be provided by Home Health Agencies as defined by State statute; other providers certified, designated or approved by the State; or by attendants hired, trained and supervised by qualified consumers or their surrogates. This includes attendants who are qualified spouses providing personal care under the demonstration (TBD).

Long-Term Care Service Descriptions

Following is a brief description of the long-term care services available to participants in the demonstration.

Personal Care Services include assistance with Activities of Daily Living (ADLs) like eating, dressing, walking, transferring, toileting and bathing. Instrumental Activities of Daily Living (IADLs) such as cooking, cleaning and shopping assistance may also be provided. Services may be provided by Home Health Agencies as defined by State statute; other providers certified, designated

or approved by the State; or by attendants hired, trained, and supervised by qualified consumers or their surrogates. Under this demonstration Vermont will expand the use of relative caregivers on a compensated basis to include spouses. The state will make the determination as to whether the spouse is able to provide the personal care services included in the enrollee's care plan and is also the best provider to do so.

Respite Care may be provided in home settings, adult day centers, residential care homes or in nursing facilities to relieve primary caregivers.

Companion Services include non-medical supervision and socialization. Companions may assist or supervise with tasks such as meal preparation, laundry and shopping; however, these tasks are not provided as discrete services. Companion services do not include hands-on personal care. Companions may perform light housekeeping tasks which are incidental to the care and supervision of the individual. Individuals providing this service must be high school graduates or the equivalent, 18 years of age or older and have training and skills that are specific and adequate to meet the needs of the participant.

Adult Day Services are community-based, non-residential services designed to assist impaired or isolated participants in remaining active in their communities while ensuring the health and independence of the individual. Services include a range of health and social services for participants and provide respite for primary caregivers. Services are furnished for a specified number of hours per day on a regularly scheduled basis, for one or more days per week.

Personal Emergency Response Systems include electronic devices which enable individuals at high risk to secure help in an emergency.

Assistive Devices and Home Modifications include items used to increase, maintain or improve functional capabilities and independence in performing ADLs or IADLs. Home modifications may include physical adaptations to the home which are necessary to ensure the health and welfare of the participant and which maintain, increase or improve functional capabilities and independence. This may include ramps, door widening, grab-bars and modification of bathroom facilities, etc., However, this service does not include repairs, maintenance or new construction. Physical adaptations in the home are limited to $750 per year per participant.

Enhanced Residential Care Home Services are a bundled package of services provided by an approved Level III Residential Care Home (RCH) or an Assisted Living Residence (ALR). In addition to services provided to all RCH/ALR residents, these residential settings also provide a Registered Nurse on-site for a minimum of one hour/week and an average of two hours of personal care services per day per participant. Daily social and recreational activity opportunities are also provided.

Nursing Facility Services include care provided in a licensed nursing facility.

Case Management Services include assisting participants in gaining access to needed long-term care Medicaid services and other state plan and community services. The case manager is responsible for the ongoing monitoring of the provision of services included in the service care plan. The case manager performs necessary assessment and reassessments of the individual's needs and reviews

plans of care at least annually (or more often if needed) to respond to changes in conditions or circumstances.

Homemaker Services include assistance with house cleaning, food preparation and clean up, and shopping for individuals who do not otherwise require personal care services.

Home-Delivered Meals include the provision of a meal(s) to an enrollee's residence.

Other Living Arrangements includes support for alternative living arrangements such as activities in residential care or assisted living residences, and other supports for home sharing, Home and Supportive Services (HASS) and adult foster care.

Bed Hold/"Leave" Days includes payment for a limited number of days when the enrollee is away from the ERC home due to an inpatient admission or for the purpose of a "home visit" (pending).

Cash and Counseling (To be Developed).

The scope and duration of services are documented in the tables included in Attachment K to this Operational Protocol. As part of the assessment process, the case manager will determine what needs can be met through existing state and community services. Services are limited to those needed to support the individual based upon their assessed needs and the care setting of their choice.

All program participants in the home- and community-based setting will receive case management services. This service will ensure that participants are fully engaged in the development of their care plans and their receipt of needed services. Case management will assist consumer-directed participants in their role as employer, and ensure that systems are in place for back-up or emergency needs, maximizing non-demonstration services and informal systems of care.

The Department of Disabilities, Aging and Independent Living is the designated state agency for administration of the Older American's Act. In that role, DAIL is responsible for the supervision of the case management providers (Area Agencies on Aging and Home Health Agencies) who are intimately involved in and aware of the scope of community services available. A referral tool is used to facilitate the identification of other organizations and programs that the applicant is currently involved with and/or may benefit from. The Independent Living Assessment tool also takes into account what other services may be provided in lieu of, or in conjunction with, the long-term care Medicaid services. In this way DAIL assures the development of a comprehensive service plan for the individual. This will also be the case for services provided to individuals with state-only grant funds.

Community Rehabilitation and Treatment (CRT) services are provided to adults with serious and persistent mental illness in accordance with the terms of the state's Section 1115 VHAP/CRT demonstration waiver. For individuals served under the long-term care demonstration, expenditures for CRT services will remain under the CRT waiver for budget neutrality accounting purposes. The two programs will collaborate on the provision of care for the small number of individuals dually served through both demonstrations. Program reporting will also separately account for CRT expenditures versus all other expenditures (see Section D) for those served through both programs.

PACE Vermont will be also administered by the Department of Disabilities, Aging and Independent Living. Expenditures (capitation payments) for these enrollees will be separately tracked and reported under the demonstration.

For nursing facility residents, the Medicare Advocacy Project (MAP) program will ensure that Medicare benefits and covered services are utilized prior to accessing payment under the long-term care Medicaid program. The Protocol for this process is included as Attachment L to this protocol.

Relative Caregivers

Under the current 1915(c) Home- and Community-Based Services waiver, family members, except for spouses serving as caregivers, are allowed to be paid as personal care attendants for waiver enrollees. This option, and the oversight of this option, will remain in place under the demonstration. Over the course of the demonstration, DAIL will also establish the parameters under which the family member personal care attendant policy will be expanded to include spouses. The Department will gather input from participants who would like to hire their spouses as attendants, and from the case managers who have knowledge of the participant's family situation. DAIL will put together a study group that will evaluate the advantages and disadvantages of such arrangements and inquire about the experience of other states that have implemented this option within their programs.

As a base of information, the state's current "Employer/Agent Certification Form " (see Attachment M) will be modified to better fit the question of the suitability of a spouse as the attendant. An evaluation of the individual will include the following components: communication skills and decision making abilities; legal status beyond spousal relationship (e.g., Power of Attorney, legal guardian); knowledge of the participant's disability and related conditions; knowledge of personal assistance needs; willingness to work with other providers of care; and employment status (outside of the home). Other areas of discussion will focus on what services are traditionally provided as a result of the spousal relationship and would not be supported financially by the waiver (e.g., preparing meals for both).

Person-Centered Planning

Vermont has more than a 20-year history in managing consumer and surrogate- directed options for elders and younger disabled adults with physical disabilities.

The state has recently received a Robert Wood Johnson Foundation grant to develop the infrastructure for a Cash and Counseling program. This program will offer an additional option for long-term care Medicaid beneficiaries. Consumers will have more options and greater personal autonomy in how to best meet their own care needs. The program allows participants greater flexibility in purchasing non-traditional Medicaid services.

Person-centered planning will be dependent upon the participant's family situation, the support of friends and other community members, as well as other service providers. The individual, together with an identified team, will determine which of his/her needs can be met with the existing available services. Planning will then focus on the gaps in available services versus the participant's needs. It will be a collaborative process in which participants are assisted in accessing the supports and services they need, based on their own preferences and values. During outreach, participants will

use a self-screening tool (to be developed) to educate themselves and evaluate the appropriateness of self-directed services and their ability to manage their own care. Participants will make the decision to voluntarily enroll in the Cash and Counseling program. After making this decision, participants will work with program consultants. These consultants will utilize the functional and clinical assessment data and work with the participant to develop an individualized spending plan. The requirement is that the goods and services be related to the participant's identified needs and their successful functioning in a community setting.

Section L: Quality Management

Overview of QM Activities

The Department of Disabilities, Aging and Independent Living (DAIL) is putting in place a multi-faceted Quality Monitoring and Management (QMM) program for this long-term care demonstration. The state's quality management program for this demonstration is described in this section of the protocol.

DAIL is the recent recipient of a CMS Quality Assurance/Quality Improvement Real Choices award, which will assist the state in developing a more comprehensive and complete quality assurance program. The structure for the quality management program reaches across all of the existing waiver programs within the department. This program is currently in the design stage and the quality management process described below may be modified as that program evolves.

Modification of the current Quality Assurance system will evolve into a program that follows the CMS Quality Framework, ensures the quality of services delivered through the Choices for Care Program and ensure the health and safety of the participant. These activities include:

- Review and approval of all plans of care for demonstration enrollees
- Desk monitoring activities conducted by LTCCC
- Service Utilization Review comparing authorized plan of care services with actual services provided
- On-site provider surveys
- On-site participant visits
- Ongoing Case Manager certification
- Consumer satisfaction surveys
- Review and analysis of Critical Incidents
- Review and analysis of complaints
- Implementation of remediation activities

The expected changes will build upon the current quality assurance activities and develop additional methods of data collection, improve methods of gathering direct consumer experiences and include a comprehensive remediation and quality improvement. The primary objective will be the development of a quality management plan addressing all HCBS and identify existing quality services and standards and quality management activities that are consistent with the CMS Framework . The second step will be to identify and develop solutions for gaps within the current quality management system. As an outcome of this activity, new service standards that include quality in the design and delivery of services, a common set of quality indicators and language across waivers and a common set of quality indicators that incorporates the CMS quality Framework will be developed to guide the delivery of service.

As quality management and data gathering activities are established, particular emphasis will be placed on the involvement of consumers and families in the discovery process. These groups will be

involved in the development of methods to directly engage them in a discovery process that elicits their experiences with the services received in the waiver program, with particular attention to the CMS Quality Framework Focus Area VI: Participant Outcomes and Satisfaction. The satisfaction data gathered will be used to effect quality improvement with the services delivered.

Quality improvement activities will also include consumers and families in providing technical assistance, specific training activities with service providers and in the development of service provider remediation plans.

As multiple methods of ongoing feedback and information gathering are developed, research of promising quality assurance practices and methods of gathering data and information that involve direct participant experiences will be incorporated into the program. This may include participant and volunteer quality review, automated participant feedback surveys (including the Participant Experience Survey and National Core Indicators surveys).

As a method to ensure participation from service providers service provider agreements will include quality assurance practices, timely methods of remediation that address deficiencies discovered through quality management activities and a system that pays particular attention to participant safeguards and timely feedback to services providers. Emphasis is on proactive response to identified issues and system of immediate response to potential area of jeopardy. As formats for remediation plans are developed, consumers and community members' input will be incorporated.

Critical to this endeavor will be the development and implementation of a technology based critical incident reporting management system. A single system of reporting and follow-up, formats and protocols will be designed to reach across the targeted waivers. The following is the list of critical incidents or events that are required to be reported to the State by service providers:

- Allegations or suspicion of abuse, neglect or exploitation of a vulnerable adult.
- Untimely death of a person.
- Missing Person
- Use of a Restraint
- Other critical incidents such as a fire, theft or destruction of property, criminal act or unusual events.

The State will act to ensure appropriate action is has been taken to address or remediate critical incidents.

In addition to the methodological strategies based on the CMS Quality Framework, the QA/QI plan involves diverse stakeholder participation. For this reason, the Quality Management System operates under a cohesive and focused work plan that directs time, efforts, and resources. Provider agencies afford the essential linkage for QA/QI plan implementation and development, and therefore a major focus of the quality management system will be to assure, strengthen, and enhance these key relations. As such, the QA/QI plan requires the following specific Provider Agency roles and responsibilities:

1) In collaboration with Choices for Care Administrative Staff, develop Provider Agreements according to State Protocols. This includes a statement of commitment to quality review processes including remediation and improvement.
2) Assure that staff and data are reasonably accessible in plan implementation, including all phases of CMS Quality Management Functions (Design, Discovery, Remediation, and Improvement).
3) Assure that the Critical Incident Reporting System is maintained and utilized according to protocol.
4) Participate on committees and workgroups to develop and fine-tune quality systems.
5) Actively be involved in providing feedback on the quality plan and its supporting documents.
6) Identify the individuals and resources necessary to ensure the implementation of internal Provider Quality Systems.
7) Provide documentation to the State of required CMS Waiver Assurances.

The Quality improvement Unit (QIU) consists of a Director, a Quality Management Development Specialist, two Team Leaders, ten Quality Improvement Specialists, and 1.5 full time equivalent Administrative Assistants. The role of the QIU is to assure that (1) all quality systems are valid, reliable, and implemented according to protocol; (2) highly skilled technical assistance is provided in implementing quality methodologies, critical incident reporting, and corrective action planning; and (3) a comprehensive, effective, and efficient Quality Management System is developed and implemented.

The Quality Management Committee (21 individuals consisting of Waiver Staff, Consumers, Family Members, Provider Agencies, and Quality Improvement Unit Staff) will serve in an advisory capacity and participate in the development of the Quality Management Plan through (1) Ongoing review of the Quality Management System (2) recommending for changes in current practice, (3) information gathering activities, and (4) other general participation in ongoing QA/QI activities.

The Division of Licensing and Protection provides critical case assessment data, surveys and licenses residential care homes, and assures the Certification of Case Managers according to State Standards.

Provider Agency Case Management Staff have important roles in (1) following State Case Management Standards; (2) following protocols for Consumer choice for care; and (3) participating in Discovery, Remediation, and Improvement methodologies.

Choices for Care Administrative Staff is responsible for assuring that provider agencies are involved in quality systems (as outlined above) through frequent Provider communication, direction of Waiver program staff, and maintenance of Provider relations.

Long Term Care Clinical Coordinator roles and responsibilities are extensive and explicit. They are outlined in Section L of the Operational Procedures.

Many agencies (e.g.: Local Advocacy Organizations, Trade Organizations, Office of Public Guardian, etc.) will have a major role in providing review and feedback on the products and processes of these ongoing quality systems through a variety of forums such as focus groups and public dissemination.

The current contract with Vermont Legal Aid for ombudsman services for individuals residing in long term care facilities is in place and scheduled to be renewed October 1, 2005. DAIL has begun negotiations and will contract with Vermont Legal Aid to provide additional ombudsman services for individuals in long term care who reside in the community. These services will be sufficient to provide statewide access to ombudsman services.

The negotiations will take place throughout August and September 2005 and a contract is expected to begin October 1, 2005. Ombudsman services are expected to be operational as this contract begins on October 1, 2005. If there are delays in hiring by Vermont Legal Aid, ombudsman services are expected to be available in early November.

Quarterly and annual reports to CMS will be supplemented by attachments that describe the major activity within the QA/QI plan including:

- Aggregated findings of qualitative and observational data reports such as interviews, site visits, and focus groups (annual reports)
- Aggregated findings of quantitative data reports, such as surveys (annual reports)
- A standardized report that provides ongoing quantitative statistics related to several CMS Framework Desired Outcomes and general service utilization indicators (quarterly reports)
- A quality management utilization narrative that describes how the QA/QI plan has directly contributed to assuring and improving the quality of services for consumers during the report period (annual reports)
- An aggregated summary and basic qualitative analysis of complaints submitted to the Ombudsperson during the report period (quarterly and annual reports)

An aggregated summary and basic qualitative analysis of critical incidents submitted during the report period (quarterly and annual reports)

The current quality management program encompasses a range of activities that include the following:

- review and approval of all plans of care for demonstration enrollees
- other desk monitoring activities conducted by LTCCC
- tracking of the services actually provided versus those included in the care plans
- on-site provider surveys
- on-site participant visits
- ongoing case manager certification process
- consumer satisfaction surveys

The quality indicators established for the demonstration contain universal provider standards that are applied to all providers of services and service specific standards which address the particular elements unique to each service and its delivery. A complete description of these standards can be found in Attachment N.
The Division of Licensing and Protection conducts an annual survey of the Home Health Agencies on a rotating basis. The survey results are shared with the Division of Disability and Aging Services for review and follow-up as needed.

The Area Agencies on Aging case managers must be certified and are required to attend periodic training to ensure they retain the knowledge necessary to adequately serve the demonstration population. The Department also monitors how case managers are incorporating their decision-making skills into service plans for participants through several review methods.

On a day-to-day basis, the LTCCCs will be overseeing the assessment process and, as the lead persons for the waiver teams, will be familiar with the issues impacting service delivery. The LTCCCs will be responsible for ensuring the success of this demonstration from a clinical perspective on a day-to-day basis.

DAIL program standards require case managers to have at least monthly contact with participants. This practice helps instill a certain degree of confidence in the safety and welfare of the participants. Complaints of abuse, neglect and exploitation are investigated in-house and then referred to Adult Protective Services, a unit within the Division of Licensing and Protection, or the Medicaid Fraud Unit for follow-up.

As a matter of policy, the Department conducts background checks for caregivers that are employed through the consumer and surrogate-directed programs. Details of this process are presented in Section M: Self-Directed Supports.

DAIL contracts with Vermont Legal Aid for Long Term Care Ombudsman services for residents in nursing facilities and Residential Care Homes. Under the demonstration, DAIL will expand this contract to include Ombudsman services for all individuals served through the program. This will ensure that all program participants have access to an independent entity responsible for representing their interests.

Utilization Review (UR)

The local DAIL LTCCCs will make all Level of Care determinations. The process consists of a review of assessment documents and follow-up phone calls and face-to-face interviews with applicants, as necessary. With the state staff making the initial Level of Care determinations, DAIL will ensure a more consistent application of the standards used for decision-making. The overall objective of the DAIL clinical oversight processes is to ensure that the services included in care plans are appropriate, both in scope and volume, relative to the identified needs of the individual participants in the demonstration.

Periodic review by the DAIL central office staff of the LTCCCs determinations will be put into place. This practice will provide a second level "check and balance" system for the oversight of LTCCC decisions.

Following is an overview of the basic steps undertaken by LTCCC during the UR process with respect to services provided in the home-based and ERC setting.

<u>Review Process for Participants Receiving Care in a Home-Based or ERC Setting</u>:

1. LTCCC review documents for completeness, including all necessary signatures by the case manager, the consumer or legal representative and the surrogate (when applicable).
2. LTCCC review the assessment information, with particular emphasis on health and functional needs.
3. LTCCC review the proposed Service Plan, personal care worksheet (home-based), Tier worksheet (ERC) and service volume.
4. LTCCC document any concerns or actions on a UR form, including conversations with case managers or providers.
5. LTCCC follow-up with case managers or service providers regarding any questions or concerns.
6. LTCCC consider variables such as, but not limited to:
   - → health status of the individual
   - → functional needs of the individual
   - → total number of people living in the individual's household
   - → size of the living environment
   - → utilization of other LTCM services (such as adult day services in the home-based setting)
   - → utilization of non-LTCM services, including paid and unpaid help (such as Medicare home health services or family)
   - → variance requests submitted by the case manager
7. LTCCC shall make adjustments to the Service Plan, when appropriate, according to LTCM eligibility requirements, service principles, definitions, standards and limitations.
8. LTCCC shall notify the case manager when a Service Plan is being adjusted (if appropriate).
9. LTCCC shall send a copy of the adjusted Service Plan to the individual and providers, including appeal rights.

Following is an overview of the basic steps undertaken by LTCCC during the UR process with respect to services provided in the nursing facility setting.

Review Process for Participants Receiving care in a Nursing Facility Setting:

This utilization review (UR) plan is for use with all Vermont long-term care Medicaid recipients who apply for initial admission to a nursing facility, or who reside in Vermont nursing facilities, and for all Medicaid recipients who may be residing in a Vermont Medicaid approved facility outside the state.

Transitional Provision (NF) (Coverage)

A. All individuals who are receiving Medicaid nursing facility care at the time of the implementation of the Choices for Care Program shall be enrolled in the Choices for Care Program and shall continue to receive services. Thereafter, these participants shall continue to be enrolled in Choices for Care if, at reassessment, they continue to qualify for the Highest Needs group or the High Needs group.

B. If an individual described in the preceding paragraph is found ineligible at reassessment under both the Highest Needs criteria and the High Needs criteria, the individual shall then be assessed under the Guidelines for Nursing Home Eligibility adopted in April 1997 (the criteria in effect prior to the implementation of Choices for Care). If the individual is found eligible under the Guidelines for Nursing Home Eligibility adopted in April 1997, the individual shall be deemed eligible for the High Needs group and shall continue to be enrolled in the High Needs group. If the individual is found ineligible under the Guidelines for Nursing Home Eligibility adopted in April 1997, the individual shall be deemed ineligible for the Highest and High Needs groups and shall be disenrolled from the waiver.

Admission to a Nursing Facility (NF) (Coverage)

1. LTCCC shall review documents for completeness, including all necessary signatures by the case manager, the consumer or legal representative, or the surrogate.
2. LTCCC shall review the assessment information, with particular emphasis on health and functional needs.

Continued Stay

Using the procedures and format specified by the state, each resident is periodically assessed and classified into the Medicaid case mix system based on the results of the comprehensive assessment. If the resident is classified into one of the case mix categories deemed by the state as automatically meeting NF criteria a continued stay is approved. If the resident does not automatically meet the eligibility criteria, the following procedures will be used:

→ On a quarterly basis the Division of Licensing and Protection (DLP) will generate a facility roster that will identify current residents who, because of their case mix classification, may require review for continued stay eligibility. DLP will provide the information to the appropriate LTCCC. The LTCCC will review the facility list of affected residents to determine if any resident on the list requires a LOC review. If it is deemed a review is necessary, the LTCCC will contact the facility, identify which residents are in need of LOC review and conduct the review. The review process will include collecting information on the resident's most current Minimum Data Set (MDS) assessment and any other pertinent current or historical information regarding functional status, medical condition that is relevant to the resident's need for nursing home placement. If, based on the LOC review, the resident is determined to meet the eligibility criteria for nursing facility placement and the needs of the resident can be most effectively met in a NF, a continued stay is approved. If it is determined that the individual does not meet the eligibly criteria for continued NF placement or that the needs of the individual cannot be most effectively met in the NF, the continue stay will be denied in accordance with the procedures described below.

Continued Stay Denials

1. When the LTCCC has determined that the NF resident is no longer eligible for NF placement the following will occur:

   → The LTCCC will inform the facility administrator or designee that the resident is not eligible for continued NF placement and request that discharge planning be initiated.

- → If the facility does not agree with the determination, the NF has the opportunity to discuss the reasons why they disagree and submit additional information for consideration. The LTCCC, prior to making an eligibility determination, will consider all additional information regarding the residents care needs, safety factors, risk factors, psychosocial needs, or other pertinent information.

2. If the facility does not agree with the determination based on the review of additional information the next steps will occur:
   - → The LTCCC will conduct an on-site visit to the facility to observe and evaluate the resident's functional and medical status.
   - → The LTCCC will contact the resident's attending physician to obtain historical and current medical information before a final determination of the individual clinical eligibly is made.

3. If the LTCCC determines that the resident is not eligible for NF placement, the facility and the resident will be informed, in writing, within two working days that the resident is not qualified or eligible for continued nursing home placement. The following steps are taken:
   - → Denial Letter: An original of the denial letter is sent to resident and or his/her legal representative, with a copy to both the attending physician and the facility.
   - → DCF Notification: A notice is sent to Local DCF office with a copy to the facility, resident (and/or legal representative), and the attending physician.

Notification will include a description of the appeal and fair hearing rights.

No Appropriate Placement Available (NAPA)

When either a resident's continued stay has been denied, or the attending physician has written a discharge order and no appropriate placement is available, the resident will be placed on NAPA status. DAIL will monitor discharge planning activity regularly until discharge occurs.

Monitoring Program

The Department has several methods for ensuring that the Level of Care decision-making process is appropriately correlated with the participant's service needs, particularly with respect to the development of the Plan of Care. The LTCCCs will be responsible for the ongoing review, approval, and monitoring of the care plans for each program participant. The focus of their review will be centered on the inclusion of an array of services that are clinically appropriate given the individual's unique set of circumstances and any health and safety risk factors, and that the plan addresses the individual's personal goals. They will also ensure that the amount, duration and scope of services is adequate to meet the individual's needs and that, to the greatest extent possible, the individual's freedom of choice of provider is maintained.

DAIL tracks the contents of all care plans and compares the actual utilization of services by the participant to those services included in the care plan. Other standard monitoring practices include reviews of case management records; interviews with program participants, surrogates and other

related individuals; and a comprehensive complaint monitoring system that includes verification of the complaint, fact finding, resolution and data analysis.

Comparative analyses will be conducted across the Plans of Care developed by the Area Agencies on Aging versus those prepared by the home health agencies. These comparisons will examine the degree of variability among the plans across like populations. Where plans are deemed to be inadequate, a corrective action plan will be required and closer monitoring will be done specific to the individual case manager. Data analysis will be used to further assess the content of the Plans of Care through the DAIL database system. This system enables the Department to compare and contrast the care plans developed by different agencies across like populations. This system will also be used to monitor the quantity of services provided on an individual and aggregate basis for each of the regional case management organizations.

Certification of Case Managers

All providers are required to meet DAIL's licensing and certification requirements or established standards. DAIL has the primary responsibility for ensuring appropriate licensure and certification of all providers. The staff in the DAIL central office is responsible for monitoring provider status. Non-licensed, non-certified providers are also required to meet certain standards established by DAIL (see Attachment I – Employer Handbook). Any provider found to be out of compliance will be notified of the required corrective action to continue as a demonstration provider.

All case managers must be certified by the state. Certification standards include a requirement to complete 20 hours per year of professional development education and an annual training program. Certification remains in effect unless revoked by DAIL. Revocation will occur when there is clear evidence that quality case management services, consistent with DAIL Case Management Standards, are not being provided and/or professional development and training has not been maintained. If a determination is made that an individual case manager is not otherwise performing up to state standards, a discovery and remediation system is activated.

Fiscal Integrity (non-duplication of payments)

The Vermont Agency of Human Services, AHS, will ensure through its Medicaid Management Information System (MMIS) and its claims processing contractor (EDS) that there is no duplication of payments for services rendered through the various Medicaid waivers and programs. The MMIS contains logic to identify duplicate claims, regardless of the funding source/program, thereby preventing duplication of payment.

The MMIS maintains a "Demographic Modifier" table that is used to match Medicaid enrollees to specific programs, including the VHAP 1115 Waiver, CRT, PACE and the Choices for Care 1115 Waiver. The Demographic Modifier table includes the recipient id and the start/end dates for enrollment in these specialized programs. The Demographic Modifier logic enables the system to assign payment responsibility to a specific funding source, as well as maintain other edits. For example, if a claim is submitted for a service provided while an individual is enrolled in the (capitated) PACE program, the claim will be denied.

The MMIS has the capacity to maintain multiple Demographic Modifiers for the same eligibility record. For example, an individual could be simultaneously enrolled in the CRT Waiver and the Choices for Care Waiver. In these cases, the logic will incorporate a hierarchy to ensure that the payment responsibility is assigned to the appropriate program.

With regard to services that are reimbursed outside the MMIS, the state relies on a number of other reporting and monitoring tools to prevent duplicative payments.

The Medicaid program and the Department of Disabilities, Aging and Independent Living have policies and procedures to ensure that financial reporting and monitoring for non-Medicaid funded programs, such as the Older Americans Act, are coordinated with Medicaid funded programs. The Medicaid Provider Participation Agreement prohibits providers from billing Medicaid (as the payor of last resort) for any service that has been reimbursed or funded by another source. The state's Medicaid Fraud Detection Unit monitors compliance with this requirement through periodic claims reviews and provider audit activities.

As the administrator of federal grant programs, the Department monitors provider activities to ensure that providers are meeting contractual obligations with regard to service delivery and reporting. Agreements with providers specifically identify the types of services that may be supported with grant funds. The Department monitors compliance through periodic reviews of providers' service reports, financial reports, and individual case files.

Financial monitoring exists on several levels. The Director of the Department's business office reviews the A-133 Audit and conveys to the Division staff any identified areas noted for correction and appropriate action. The business office issues a monthly monitoring report to appropriate personnel that compares actual expenditures to planned expenditures, and provides an assessment of any over or under payments. This report is reviewed by DAIL management on a monthly basis and programmatic adjustments are made as necessary.

Oversight and monitoring of the Intermediary Service Organization (ISO) for employer support services within the consumer and surrogate-directed services program is conducted via monthly meetings and through data submission and claims review (See Section M).

Section M: Self-Directed Supports – Education, Counseling, Fiscal Intermediary & Support Services

The State of Vermont has a long history with self-directed supports for individuals accessing personal care, respite and companion services. The existing system will be maintained under the demonstration.

Program participants are counseled at the time of enrollment about the three options through which they may have their services delivered: consumer directed, surrogate directed and agency directed. The consumer-directed model establishes the participant as the employer of their Personal Care Attendant (PCA) with all the rights and responsibilities of an employer. The surrogate-directed option allows the participant to appoint another person to act as his/her agent and the employer. The agency-directed option provides all services through an appropriate home health agency.

Access to the self-directed support option is offered through the individual's case manager. The case manager is also responsible for assisting the individual in understanding the obligations and limitations of this service utilization option. An employer handbook (see Attachment I) is made available to participants at the time they are determining whether this is how they want to have their services delivered. Services available under this system are limited to personal care, respite and companion services.

All consumers must be screened as to their ability and willingness to direct their own care prior to being approved for this option. Eligibility guidelines include the ability to understand and perform the tasks required to hire a caregiver and the ability to communicate effectively with the case manager and caregiver in performing the tasks required of the caregiver. If an individual does not meet the criteria for consumer-direction, they may be offered the option of selecting a surrogate to act as an employer agent on their behalf. All consumer or surrogate-directed employers are verified and documented by the case manager as to their competency. The case manager is charged with the responsibility to monitor the employer's ongoing abilities during the monthly contacts and at the time of the annual reassessment.

If an individual or surrogate is deemed to no longer be able to act as the employer they are notified in writing by the case manager. At that time they are offered the option of continuing their services through the agency directed option.

The Intermediary Service Organization (ISO), which provides employer support services for this program, is enrolled with Medicaid as a provider and has a written contract with the Agency of Human Services to provide those services. (See Attachment O). The state currently contracts with one payroll agent (ARIS) to provide employer services for consumer and surrogate-directed services. This contract delineates the scope of services to be performed, the terms and conditions of the agreement, reporting mechanisms, payment methods, and oversight requirements. The contract is competitively bid every three years.

Consumer or Surrogate employers and their employees (Personal Care Attendants) must enroll with the ISO, including filing all employment forms as required by law. Personal Care Attendants do not enroll directly as Medicaid providers. This is a continuation of DAIL's current process.

The ISO is evaluated at least annually during the term of the contract and is monitored monthly. The evaluation may include an assessment of cost-effectiveness, access, communication with participants, ability to meet payroll and non-payroll goods and services payment schedules, ability to process payment requests promptly, timeliness of applicable federal and state payroll reporting requirements and other relevant areas of performance.

Background checks are performed on behalf of the employer by the ISO. Background checks include information on any substantiated complaints of abuse, neglect, and exploitation made to the Department of Children and Family Services or the Division of Licensing and Protection. A request for information on criminal convictions is made to the Vermont Crime Information Center. References are also obtained from previous employers and others who can provide character references for the prospective employee.

Section N: Participant Protection for Self-Direction

The Department of Disabilities, Aging and Independent Living has developed a comprehensive approach to ensuring the viability and appropriateness of its consumer and surrogate-directed services programs.

At the time of application, case managers provide all potential recipients of home and community-based services with information on their service options, including consumer or surrogate direction of personal care services. Those who express an interest in this service delivery option are evaluated to determine if the consumer or surrogate meets the criteria for performing this function. Those who may meet the criteria are given further information, via the state's Consumer and Surrogate Directed Services Handbook (see Attachment I) which covers all aspects of the program and the individual's responsibilities as an employer.

Additionally, Vermont contracts with an Intermediary Services Organization (ISO) to provide employer support services and technical assistance. ISO services include enrolling employers and employees into the payroll system, processing timesheets, issuing payroll checks, processing taxes and withholding in accordance with state and federal law, processing workers' compensation claims, and unemployment benefits.

If at any time a case manager determines that an individual or his/her surrogate is unable to continue as the consumer or surrogate director, and an alternate surrogate cannot be identified and trained, the individual will be enrolled in agency directed services.

Emergency Back up and response

At the time the plan of care is developed with the case manager and the participant, the case manager will assist the individual in developing an emergency back-up plan. This plan will indicate at least one individual or agency to contact in the event that a personal care worker does not show up for work. A list of emergency contact will also be developed. A copy of the plan will be placed in a conspicuous location in the participant's home. The case manager will also maintain a copy of the plan in their files.

Cash and Counseling

Attachment S outlines the implementation plan and current working timeline for Cash and Counseling is included. Cash and Counseling budgets will be developed on a monthly basis, adjusting for months of different lengths. The person-centered planning process outlined in l.6 will emphasize the responsibility of the consumer to manage their allocation and work to limit the incidence of funds being used up too rapidly. Second, the planning process will include the development of emergency and back-up plans so some consumers will be aware of resources available to them when their care plans cannot be implemented, for whatever reason

An important part of the Cash and Counseling concept is the consumers' ability to "save," i.e., to purposefully not spend their entire allotment for a month in order to either have a "nest egg" available for care emergencies or for big-ticket items which cost more than the consumer can afford based on one month's allocation. The Financial/Employer Agent will be responsible for tracking

these "saved" funds. There will, however, be a limit on these funds, although that limit is, as yet, undecided. Other Cash and Counseling states have used a limit of between 1 and 2 month's allocation.

Section O: Financial Incentives for the Purchases of Long-Term Care Insurance by Individual Vermonters

The Department will create a workgroup during the first year of the demonstration, led by a member of the Department of Children and Families Economic Services Division, to evaluate options for providing financial incentives for the purchase of long-term care insurance. Current plans for the membership of the workgroup include representatives from:

- ✓ Division of Health Care Administration
- ✓ Division of Disability and Aging Services
- ✓ Division of Economic Services
- ✓ AARP
- ✓ Long-Term Care Ombudsman
- ✓ State Health Insurance Assistance Program
- ✓ Elder Law Committee of the Vermont Bar Association
- ✓ Long-Term Care Insurance Brokers/Carriers

During the second year of the demonstration, the workgroup will explore strategies for implementing options for providing financial incentives for the purchase of long-term care insurance as identified in the first phase of planning. It is expected the financial incentives to be further evaluated will include:

- Incentives for blended life/annuity policies
- Incentives for reverse mortgages
- Incentives for creation of group policies by employers
- Partnership policies. This strategy is currently obstructed by OBRA 1993, which contained language that has a direct impact on the expansion of partnerships for long-term care. States seeking new partnership strategies must abide by the conditions outlined in OBRA '93, including the following:
  - → Section 1917(b) paragraph one subparagraph C: requires any state operating a partnership program to recover from the estates of <u>all</u> persons receiving services under Medicaid, limiting the asset protection component of the partnership to the insured's lifespan. After the participant dies, states must recover what Medicaid spent from the estate, including protected assets.
  - → Section 1917(b) paragraph 3: prevents a state from waiving the estate recovery requirement for partnership participants.
  - → Section 1917(b) paragraph four subparagraph B: requires a specific definition of "estate" for partnership participants. States implementing a partnership may be forced to use a broader definition of estates for partnership participants as a distinct group.

The financial and administrative feasibility of implementing the options identified will also be examined during demonstration Year 2.
Based on the outcome of the workgroup's feasibility study, the state will consult with the Legislature on the development of statutory language to permit the incentives to be put in place. It is anticipated that this would occur in demonstration Year 3.

Section P: Grievances & Appeals

Individuals are given the opportunity to appeal decisions made by the LTCCC relative to program or clinical eligibility or the services provided in their plan of care through the procedures outlined below. These decisions are considered "Actions" and include the following:

- a clinical or financial eligibility determination
- the denial or limited authorization of a requested service
- the reduction, suspension or termination of a previously authorized service or range of services

Clinical Eligibility & Services Appeals

Clinical eligibility denials made by LTCCC will result if the applicant does not meet the clinical eligibility criteria for receiving long-term care services, or because they have a primary diagnosis that would be more appropriately served through other state programs (e.g., CRT program). In these cases, the individual will receive a written notice from DAIL that includes information on the basis of the denial and an explanation of the appeal process (see Attachment P).

Based upon utilization review activities, LTCCC may end or reduce services an individual has been receiving. In these cases, LTCCC will send a notice of decision at least eleven (11) days before the decision will take effect. That notice will also explain the individual's appeal rights.

The individual may appeal either type of action with or without legal representation. Individuals who desire legal representation are informed that they may contact Vermont Legal Aid for such assistance.

In order to appeal, the individual or their representative must request, in writing, an administrative review within thirty (30) days of receipt of an eligibility denial notice or notice of a denied or reduced service plan. If a service reduction or denial appeal is filed by the recipient within eleven (11) days of the notice of the reduction of a previously authorized service, those services will continue pending the outcome of the appeal. If the recipient does not succeed in having the service reduction or denial overturned either through the DAIL administrative review process or through a fair hearing, s/he may be held financially accountable for the cost of the services provided during the interim period.

Upon receipt of the request for an appeal, DAIL will perform an administrative review of the individual's circumstances, examine case records, request additional information as needed from their case manager, and/or conduct an in-person interview, if necessary. Once sufficient information is obtained and reviewed, a final administrative review decision will made and a second notice will be issued. If the denial or reduction in services is upheld, that notice will include information on additional appeal rights. Individuals are informed at the time of application, assessment and re-assessment plan of care development, verbally and in writing, of the possibility that they may be responsible for the cost of services provided during the appeals.

Further appeals of the administrative review decisions of DAIL may be made to the Human Services Board within 90 days of receipt of the decision. Individuals enrolled in the demonstration always have the right to appeal directly to the state's Human Services Board.

The Long-Term Care Ombudsman is available, through Vermont Legal Aid, to provide assistance to individuals in the filing and processing of their appeals.

An applicant or participant may make a request for reconsideration to the Department regarding determinations of clinical eligibility, termination of eligibility, and the type or amount of services authorized. A request for reconsideration may be made to DAIL at any time.

Financial Eligibility Appeals

Individuals may also appeal a denial of long-term care Medicaid financial eligibility or patient share determinations. Appeals of financial eligibility determinations shall follow regulations promulgated by the Department for Children and Families. The current regulations contain the following provisions: Appeal rights and procedures are communicated in a letter issued by the Department for Children and Families/Economic Services Division at the time the individual is notified of their eligibility denial or patient share of cost. The individual must file his/her appeal within 90 days of the mailing date of the notice from DCF, either in writing or by calling their local DCF office. The individual may also appeal directly to the Human Services Board.

Should the individual first file an appeal with DCF/ESD, staff will collect all relevant information on the financial circumstances of the individual as presented in their application and may further interview the applicant to obtain additional information. Following a review of the case file, DCF/ESD will either uphold or overturn the eligibility denial. All financial eligibility appeals will be processed within 30 days of the receipt of the appeal.

If the denial is overturned and eligibility is confirmed, the individual will be so noticed and coverage will be effective as of the original date of the application.

If the denial is upheld, the individual will be notified of the denial and further apprised of their right to appeal that decision to the Human Services Board. Appeals to the Human Services Board must be made within 90 days of the DCF notice of an eligibility denial.

The same process is followed for patient share of cost determination appeals.

Monitoring of Appeals

The grievance and appeal process is closely monitored internally by staff attorneys and externally by Vermont Legal Aid. DAIL program managers receive periodic reports on the number and type of appeals and their resolution timeframes and status (upheld, overturned, partially overturned). The Quality Management and Improvement unit within DAIL is responsible for coordinating corrective action when aberrant patterns of grievances and appeals are identified, or when the number of overturned appeals exceeds a certain threshold.

Section Q: Evaluation Design

The Department will create an advisory group to assist DAIL in the development of the design of the evaluation component of this demonstration. Representatives of the following organizations will be invited to participate:

- ✓ AARP, Vermont Office
- ✓ Area Agencies on Aging
- ✓ Community of Vermont Elders
- ✓ Office of Vermont Health Access (Agency of Human Services)
- ✓ Vermont Assembly of Home Health Agencies
- ✓ Vermont Association of Adult Day Services
- ✓ Vermont Center for Independent Living
- ✓ Vermont Legislature
- ✓ Vermont Health Care Association

The advisory group will also provide input to DAIL on the development of an RFP, which will be used to select an organization(s) to conduct the evaluation. The organizations Vermont anticipates contacting include the following:

- ✓ National Academy for State Health Policy
- ✓ Miami University Scripps Gerontology Center
- ✓ University of Massachusetts Center for Health Policy and Research
- ✓ Muskie School of Public Service, Institute for Health Policy
- ✓ Center for the Aging, Dartmouth Medical School
- ✓ University of Vermont

The selected evaluation contractor will be responsible for the final design of the evaluation, in consultation with the Department of Disabilities, Aging and Independent Living.

Initial elements under consideration for the evaluation component include the following:

- Changes in access to Home- and Community-Based Services
- Changes in the range of long-term care options
- Changes in the quality of long-term care services
- Changes in system performance measures (e.g. time from applying for HCBS to receiving HCBS)
- Changes in the nursing facility census and acuity levels
- Determining if services provided to members of the Moderate Needs group prevent or delay the use of more intensive services by these individuals
- Consumer satisfaction levels

Vermont has core datasets which are available for use in the evaluation. These data are collected through a variety of methods including the assessment and re-assessment process, information collected in the course of program monitoring activities, claims for services, surveys, etc. Specifically DAIL anticipates that the following datasets will be used in conducting the evaluation:

- Individual assessment data, via the SAMS 2000 database
- Medicaid paid claims
- ORC MACRO participant survey (satisfaction) data
- MDS assessment data (assuming such use is approved through a data use agreement with CMS)
- Nursing facility occupancy rates
- Results from other written, telephone or focus group surveys

Vermont will also seek to answer the following questions with respect to the demonstration:

- Which functional, cognitive and medical measures are the best predictors of individuals at risk for institutional placement in the medium term (12-24 months)?
- Is it more cost effective for the overall long-term care program to furnish a comprehensive package of HCB services to individuals based on their specific needs than to operate a system with an institutional bias? Is the overall cost lower on a per participant basis?
- If a care plan including HCB services is implemented early enough, can the need for nursing facility care be significantly delayed or eliminated?
- Are participants more satisfied under the demonstration than was the case with the historical program?
- Do educational and outreach efforts expand the level of knowledge in the community with respect to long-term care resources?

Given the comprehensive and unique nature of this long-term care demonstration, the state does not expect to encounter any problems in isolating the effects of the program on the enrolled population. The state does not expect any other long-term care initiatives of this nature being implemented during the five-year period. Basic shifts in population demographics (e.g., aging of the population) are identifiable and can be controlled for when conducting the various analyses attendant to the evaluation.

As the evaluation process unfolds, the state will use any interim findings to make improvements in its processes and procedures across all operational areas of the program. These findings will also be summarized in the state's annual report to CMS.

Attachment A – Choices for Care Brochure

To Apply:

For more information or to apply for

Choices for Care, contact the Department of Disabilities, Aging and Independent Living in the region in which you live:

Barre:	1-802-476-1646
Bennington:	1-802-442-8541
Brattleboro:	1-802-257-2820
Burlington:	1-802-879-5900
Hartford	1-802-885-8875
Middlebury:	1-802-388-3146
Morrisville:	1-802-888-2582
Newport:	1-802-334-3910
Rutland:	1-802-786-5971
Springfield:	1-802-885-8875
St. Albans:	1-802-524-7913
St. Johnsbury	1-802-748-8361

Mail to:

AIL 62
Dept. of Disabilities, Aging and Independent Living
103 South Main Street
Waterbury, VT 05671-2301

VERMONT

Vermont
Agency of Human Services

CHOICES FOR CARE

VERMONT

LONG-TERM CARE MEDICAID

Department of Disability, Aging and Independent Living
103 South Main Street
Waterbury, VT 05671-2301
Tel/TTY: 1-802-241-2400

October 1, 2005

This brochure is available in other formats upon request.

Helping Vermonters

QUESTION: Do you or a loved one need daily help with activities such as toileting, getting dressed, or eating?

QUESTION: Are you worried about how to pay for the care you need?

QUESTION: Is it important to you that you and your loved ones decide where you will receive this care?

If the answer is **"Yes"** **CHOICES FOR CARE:** VERMONT Long-Term Care Medicaid may be able help.

If you qualify, **CHOICES FOR CARE:** VERMONT Long-Term Care Medicaid pays for care in any of these three settings:

- **IN YOUR HOME**
- **ENHANCED RESIDENTIAL CARE (ERC)**
- **NURSING HOME**

IN YOUR HOME

If you are eligible, the following services are available to help you remain at home:

- Case Management
- Personal Care
- Respite or Companion Care
- Adult Day Services
- Personal Emergency Response Systems
- Assistive Devices/Home Modifications

Note: 24-hour care is not available in the home-based option.

ENHANCED RESIDENTIAL CARE (ERC)

Approved Licensed Level III Residential Care Homes and Assisted Living Residences provide services such as:

- Personal Care
- Meals
- Medication Management
- Nursing Overview
- Activities
- 24-hour Supervision
- Laundry/Housekeeping

Case Management is also provided to people in the Enhanced Residential Care setting.

NURSING HOME

Licensed Nursing Homes provide a wide range of services including:

- Personal Care
- Meals/Nutritional Services
- 24-hour Skilled Nursing
- Rehab and Therapy
- Activities
- 24-hour Supervision
- Social Services
- Laundry/Housekeeping

ELIGIBILITY

To be eligible, you must:

- Be a Vermont resident,
- Be 65 years of age or older OR 18 years of age with a physical disability,
- Meet specific clinical criteria,
- Meet financial criteria for Vermont Long-Term Care Medicaid .

Options Brochure and Information on Resources – Under Development

SAMPLE – Bennington County

Adult Day Services

Adult Day Services programs provide social, health, respite and other services for elderly and disabled Vermonters during specified hours of the week.

Contact: Bennington Project Independence, Linda Wichlac (802) 442-8136

Adult Protective Services (APS)

The Vermont Department of Aging and Independent Living receives and investigates reports of suspected abuse, neglect and exploitation against vulnerable elderly and disabled Vermonters.

Contact: Division of Licensing and Protection 1-800-564-1612

Alzheimer's Association

The Vermont Alzheimer's Association provides education, information and support services to individuals with Alzheimer's and their families.

Contact: Alzheimer's Association of VT and NH1-800-698-1022

Area Agency on Aging (AAA)

Vermont Area Agencies on Aging provide services to Vermonters over the age of 60, such as information and assistance, case management, benefits and health insurance counseling, nutrition services, mental health counseling and volunteers.

Contact: Southwestern Vermont Council on the Aging (802) 442-5436

Assistive Technology

- ✓ Miracle on Wheels – Electric powered wheelchairs, free for senior 65 or over
  Contact: 1-800-948-0527
- ✓ Vermont Assistive Technology Project
  Contact: 1-800-750-63565
- ✓ Vermont Center for Independent Living
  Contact: (802) 229-0501
- ✓ Vermont Developmental Credit Union
  Contact: 1-800-865-8328
- ✓ Vermont Division for the Blind and Visually Impaired
  Contact: Central Office/Waterbury (802) 241-2210, Rutland Office 1-800-708-7712

Assistive Technology – cont'd

- ✓ Vermont Division of Vocational Rehabilitation
  Contact: 1-866-879-67857

- ✓ Wayward Wheels – Provides used equipment
  (must agree to return equipment when finished with it)
  Contact: Mary Ryan (802) 655-2936

Attendant Services Program

The Vermont Department of Aging and Independent Living provides personal care services to adult Vermonters with disabilities through the Attendant Services Program. The participant (or designee under Personal Services) must hire, train, supervise, and schedule his or her personal care attendant(s).

Contact: Division of Advocacy and Living (802) 241-2400

BART TEAM – *The Bennington County Bart Team works with the local Long-Term Care Coalition to make money available for a wide variety of services and equipment to help people remain independent at home.*

Contact*: Southwestern VT Council on Aging (802) 442-5436*

Blind and Visually Impaired Services

The Vermont Department of Aging and Independent Living provides services such as education, support, assistive technology, and vocation training for blind and visually impaired Vermonters.

Contact: Division for the Blind and Visually Impaired: Central Office/Waterbury
(802) 241-2210, Rutland Office 1-800-708-7712

BROC

Community Action Agency serving Bennington County offers programs and services including community outreach, nutrition education, community development and housing, micro-business and energy conservation and weatherization.

Contact: (802) 447-7515

Care Giver Support Group

Contact: ***Alzheimer's Association of VT and NH1-800-698-1022***
"Caring Friend", Bennington Project Independence (802) 442-8136
Dorset Nursing Association (802) 362-1200

Dementia Respite Grant

Respite funds are available to families providing care to elderly members with Alzheimer's Disease or other dementia.

Contact: (802) 775-2593

Department for Children and Families (DCF)

The Vermont Department for Children and Families (DCF) provides financial assistance to low income Vermonters for expenses such as food, housing, fuel, medical coverage and prescription costs.

Contact: Bennington DCF District Office 1-800-775-0527

Developmental Services

The Department of Aging and Independent Living provides services for Vermonters with developmental disabilities.

Contact: Division of Developmental Services (802) 241-2614

Diabetes Information

The American Diabetes Association (ADA) provides education and information regarding diabetes treatment and management.

Contact: American Diabetes Association (802) 654-7716

EMERGENCY RESPONSE SYSTEM *– Emergency response systems are available in which your home telephone is connected directly to a local hospital or other answering service. If you are alone at home and need help, you push a button and the answering service is called automatically and sends help.*

Contacts: ***Healthwatch (802) 447-5089***
Lifeline (802) 747-1816
Link to Life 1-800-848-9399

HOME-BASED MEDICAID WAIVER PROGRAM – *The Vermont Department of Aging and Independent Living provides in-home long-term care services to elders and adults with physical disabilities who require nursing home level of care and are financially eligible for long-term care Medicaid.*

Contact: ***Division of Advocacy and Independent Living (802) 241-2400***

Home Health Care

In-home nursing, nurses aid services, physical therapy, occupational therapy, speech therapy, medical social work, personal attendant care or homemaker service are available through local Home Health Care providers.

Medicare Certified Contacts: Bennington Area Home Health & Hospice (802) 442-5502
Dorset Nurses Association (802) 362-1200
Manchester Health (802) 362-2126

Private Contacts: Homeworks (802) 442-5502
Loving Hands (802) 447-1613
Professional Nurses Service: *Bennington (802) 442-3222*
Manchester (802) 362-5488
The Registry (802) 442-2222

Homemaker Program

The Department of Aging and Independent Living provides funding for Homemaker services on a sliding fee scale through local Medicare Certified Home Health Agencies.

Contacts: Bennington Area Home Health & Hospice (802) 442-5502
Dorset Nursing Association (802) 362-1200
Manchester Health Services (802) 362-2126

Hospice

Hospice provides end-of-life care, support and services for terminally ill Vermonters and their families.

Contacts: Bennington Area Home Health & Hospice (802) 442-5502
Dorset Nursing Association (802) 362-1200
Manchester Health Services (802) 362-2126
Hospice of Bennington County: Volunteers that provide emotional and spiritual support to the terminally ill (802) 447-0307

Housing Options

Subsidized and affordable housing units located in Bennington County.

Contacts: Art Carlucci (802) 442-2307
Bennington Housing Authority 442-8000
Maloney Properties, Inc (802) 425-5500
Marken Properties, Inc (802) 254-2011
Regional Affordable Housing Corp (802) 442-8139
T H M, Inc (802) 362-4663
Vermont State Housing Authority (802) 828-3295

HOUSING AND SUPPORTIVE SERVICES – *Supportive services for individuals in certain congregate housing.*

Contacts: Brookside and Wallomsac Apartments (802) 447-7019
Cora B Whitney Senior Living Facility (802) 442-9953

MANCHESTER INTERFAITH COUNCIL – Contact: *(802) 362-1555*

MENTAL HEALTH SERVICES – *United Counseling Services provides mental health and substance abuse treatment. They have 24-hour crisis services.*

Contacts: Northshire United Counseling Services (Manchester) (802) 362-3950
United Counseling Services (Bennington) (802) 442-5491

NURSING HOMES – *Nursing homes provide 24-hour care for individuals who require nursing, medical, rehabilitation, or other special services. They are licensed by the state and may be certified to participate in the Medicaid and/or Medicare programs. Certain nursing homes may also meet specific standards for subacute care or dementia care.*

- ✓ Bennington Health and Rehabilitation Center
  2 Blackberry Lane
  Bennington, VT 05201
  Contact: (802) 442-8525

- ✓ Centers for Living and Rehabilitation
  160 Hospital Drive
  Bennington, VT 05201
  Contact: (802) 447-5482

- ✓ Crescent Manor Care Center
  312 Crescent Blvd
  Bennington, VT 05201
  Contact: (802) 447-1501

- ✓ Prospect Nursing Home
  34 Prospect Street
  Box 878
  North Bennington, VT 05257
  Contact: (802) 447-7144

- ✓ Vermont Veterans Home
  325 North Avenue
  Bennington, VT 05201
  Contact: (802) 442-6353

NUTRITION/FOOD PROGRAMS

Home-Delivered Meals: Persons over 60 and their spouses who are isolated or frail and certain disabled persons under 60 may qualify for meals home delivered up to five times a week. No charge, but donations invited.

Contact: Southwest VT Council on Aging 1-800-642-5119

Senior Meals: Hot meals served in a social setting anywhere from daily to several times a month. Available at no charge (donations invited) to Vermonters over 60 and their spouses of any age, plus certain others. There are meal sites in these southwestern Vermont towns: Arlington, Bennington, East Dorset, Manchester, Poultney, Pownal, Shaftsbury, Wells.

Contact: Southwestern VT Council on Aging 1-800-642-5119

Community Kitchens

- ✓ **Harvest House**
  945 East Main Street
  Bennington, VT
  Contact: Pastor Bob Lebert (802) 447-4739

Food Shelves

- ✓ Arlington Food Shelf, Inc
  East Arlington, VT
  Contact: Anna Hawley (802) 375-2231

- ✓ BROC
  Bennington, VT
  Contact: Food outreach worker (802) 447-7515

- ✓ Bible Baptist Church
  Bennington, VT
  Contact: Eleanor Twardy (802) 447-3618 or (802) 442-4281

- ✓ Sacred Heart St Francis De Sales Parish Center
  Bennington, VT
  ***Contact*: Constance Kuhn (802) 442-7504 or (802) 442-3141 Food Shelves – cont'd**

- ✓ St John the Baptist Food Pantry
  North Bennington, VT

***Contact:* Jill Levin or Mae Fox (802) 447-7504**

- ✓ **First United Methodist Church**
  Bennington, VT

  Contact: Rev G Eberly or M Roberts (802) 442-5920

- ✓ North Bennington Baptist Church
  North Bennington, VT

  Contact: Pastor D Jinno (802) 442-2711

- ✓ Door of Hope
  Heartwellville, VT

  Contact: M Sweeney or J Chenail (802) 423-7560

- ✓ Community Food Cupboard
  Manchester, VT

  Contact: Martha Bishop (802) 362-0057

- ✓ Pownal Food Pantry
  Pownal, VT

  Contact: D Maturski (802) 823-7763 or P Willette (802) 823-5337

- ✓ Community Food Pantry
  Pawlet Community Church

***Contact:* Ellie Lee (802) 325-3381**

Office of Public Guardian

The Vermont Department of Aging and Independent Living provides court appointed guardian services to elders and individuals with developmental disabilities.

Contact: Division of Developmental Services (802) 241-2614

Residential Care Homes

- ✓ Residential care homes are state licensed group living arrangements designed to meet the needs of individuals who cannot live independently and usually do not require the type of care provided in a nursing home. When needed, help is provided with daily activities such as eating, walking, toileting, bathing, and dressing
- ✓ ***Level III Homes***

  - Autumn House
    141 South Branch Street
    Bennington, VT 05201

    Contact: David Ramos (802) 442-1243

  - Equinox Terrace Association
    324 Equinox Terrace Road
    Manchester Center, VT 05200

Contact: Carol Wright (802) 362-5141

- Manes House (ERC)
  127 Union Street
  Bennington, VT 05201
  Contact: Holly Baker (802) 442-8900

- Rivers Edge (ERC)
  5 Hunt Street Ext.
  Bennington, VT 05201

- Vermont Veterans Home
  325 North Street
  Bennington, VT 05201
  Contact: Earle R Hollings (802) 442-6353

- Village at Fillmore Pond (ERC)
  300 Village Lane
  Bennington, VT 05201
  Contact: Michele Ruggiero (802) 447-7000

- Washington Elms
  126 Elm Street
  Bennington, VT 05201
  Contact: Melissa Greason (802) 447-1219

- Watson House

34 Prospect Street
North Bennington, VT 05257
Contact: Debra Hale (802) 447-1161

✓ ***Level IV Homes***

- Fairwinds Residential Care Home

108 Mechanic Street
North Bennington, VT 05257
Contact: Wanda King (802) 442-4067

- Twin Maples Community Care Home
  612 Gage Street
  Bennington, VT 05201

***Contact:* Sarah Davenport (802) 447-2274**

RESPITE CARE – Contact*: Southwestern Vermont Council on Aging (802) 442-5436*

Senior Helpline

Information and referral services for Vermonters 60 years of age and over.

Contact: 1-800-642-5119

Social Security

The Social Security Administration processes benefits for Social Security retirement, Supplemental Security Income (SSI), disability and Medicare benefits.

Contact: (802) 775-0893 or 1-800-772-1213

Substance Abuse

Contacts: Northshire United Counseling Services, Manchester (802) 362-3950
United Counseling Services, Bennington (802) 442-5491
Division of Alcohol and Drug Abuse Programs (802) 651-1550

TRAUMATIC BRAIN INJURY (TBI) PROGRAM – *The Vermont Department of Aging and Independent Living provides rehabilitation, care and supportive services to Vermonters with traumatic brain injuries who would otherwise require services in an out-of-state facility to meet their needs. Individuals must be eligible for VT Long-Term Care Medicaid.*

Contacts: Division of Vocational Rehabilitation (802) 241-2186
Bennington Area Home Health & Hospice (802) 442-5502
Dorset Nursing Association (802) 362-1200
Manchester Health Services (802) 362-2126

TRANSPORTATION – *Red Cross Transportation for elders and medical needs.*

Contacts Bennington Red Cross (802) 442-9458
Manchester Red Cross (802) 362-1985

Veterans Services

The United States Veterans Administration provides various medical services, counseling, home leans, insurance, burial benefits, education, and employment assistance to eligible veterans of the United States armed forces.

Contacts: Department of Veteran Affairs 1-800-827-1000
Vermont Veterans Affairs Office (802) 828-3379

VERMONT CENTER FOR INDEPENDENT LIVING (VCIL) – *VCIL provides support to Vermonters with disabilities through peer advocacy counseling. Individuals learn skills for living independently, gain experience in solving problems related to their disabilities, and choose where and how to live. Home Access Program helps fund modifications to homes.*

Contact: (802) 447-0574 or 1-888-266-1574

Vermont Legal Aid

Vermont Legal Aid provides legal assistance and referral to low income Vermonters.

Contacts: VT Disabilities Law Project (802) 775-0021
VT Senior Citizens Law Project (802) 775-0021

VT Ombusman Program (802) 775-0021
Client Assistance Project 1-800-747-5022

Vocational Services

✓ Bennington Career Resource Center
Contact: (802) 442-6376

✓ Vermont Associates for Training and Development
Contact: 1-800-439-3307

✓ Vermont Department of Employment and Training
Contact: (802) 828-4000

✓ Vermont Division for the Blind and Visually Impaired
Contact: Central Office/Waterbury (802) 241-2210, Rutland Office 1-800-708-7712

✓ Vermont Division of Vocational Rehabilitation
Contact: 1-866-879-67857

Volunteer Opportunities

✓ Green Mountain Foster Grandparent Program
Contact: (802) 773-4719

Volunteer Opportunities – cont'd

✓ Guardian Services
Contacts: Bennington Probate Court (802) 442-2705
Manchester Probate Court (802) 362-1410

✓ Hospice Services
Contacts: Bennington Area Home Health & Hospice (802) 442-5502
Dorset Nursing Association (802) 362-1200
Manchester Health Services (802) 362-2126
Hospice of Bennington County (802) 447-0307

✓ Retired Senior Volunteer Program
Contact: (802) 447-1545

✓ SCORE Counselors to America's Small Business
Contacts: Champlain Valley (802) 951-6762
Montpelier (802) 828-4422
Newport (802) 334-6322

✓ Senior Companion Program
Contact: (802) 442-5436 or 1-800-642-5119

✓ Southwestern Vermont Council on Aging

Contact: (802) 442-5436 or 1-800-642-5119

- ✓ United Way

  Contact: (802) 442-4947

- ✓ VT Department of Corrections Mentors/Volunteers

  Contact: (802) 241-2269

- ✓ VT Ombusman Project

  Contact: 1-800-769-7459

- ✓ Vermont Sunshine Society

Contact: (802) 885-3672homes provide nursing overview, but not full-time nursing care. ***Level IV*** homes do not provide nursing overview or nursing care.

Attachment B STAFF TRAINING

Week 1				
Mon. 8/15/05 Stanley Hall Rm 100 **Orientation:** **A.M. 9:00am start** • Introductions • Welcome: Patrick, Theresa, Lorraine, Adele • Department Mission • Goals/Philosophy • AHS/DAIL/DDAS org chart • "Getting to know you" **10:00am** Darlene Brown & Linda McGrath from Personnel. **11-12** Tour, credit union, cafeteria **P.M. 1:15-3:15** VT Interactive TV (VIT) provider training (observe)	**Tues. 8/16/05** **Off-HOLIDAY**	**Wed. 8/17/05** **Stanley Hall Rm 100** CMS rep observing (Chong) **A.M. 9am start** **9:00** Job responsibilities – Megan/Nancy **9:30-10:15 Joan Senecal** • Describe her role • History of VT LTC • 1115 Waiver process **10:15 –12:00** General: • General program description • Acronyms • Identify Manuals/Regs/Tools • Provider types & lists • Up-and-coming changes • Transition- then and now (chart) **1:00-2:00 P.M.** Scavenger Hunt **2:00-4:00** • Application/referral process "At a Glance" Set up provide visits for Friday & study materials	**Thurs. 8/18/05** **Appalacian Gap** **A.M. 9:00** • CMS, expectations, transition dates, etc. • Negotiated Risk 10:30-12:00 Judy Peterson - **Self-Determination** **1-4:00 Deb Coutu** • RN Experiences & Strengths • Clinical Eligibility-History Services "At a Glance" – If time permits **4:00-4:30** Timesheets/expense sheets Updates – **space**	*Fri. 8/19/05* **In the community** **All day** • Visit providers • Check out office • Study materials Stanley Hall Rm 100 available

Week 2				
Mon. 8/22/05 **Stanley Hall Rm 107** **A.M. 9:00-12:00** Forms Home-Based setting • Services • Consumer/Surrogate directed • ILA • Providers • Limitations **P.M 1:00 -4:00** Community services-Provider Representatives • 1:00-1:45 ISO Maryann Willson • 1:45-2:30 -AAA Beth Stern • 2:30-3:15Adult Day & DHRS Lynn Bedell • 3:15-4:00 Homecare Nancy Butryman	**Tues 8/23/05** **Stanley Hall Rm 107** **A.M. 9-11 Res. Care** • RCHRACT • Licensing Rags • Life Safety • Services • Provider enrollment • Variances • Max capacities • Providers • Discharges • Bed-hold/leave days **11am** Provider – Pam Favreau **P.M.** • 1:00 Homemaker-Megan Tierney-Ward • 2:00 Cash & Counseling – Merle Edwards-Orr • 2:45 Dementia Respite Grant – Maria Mireault	**Wed. 8/24/05** **Stanley Hall Rm 107** **A.M. 9:00-10:00** Bard Hill – UR in terms of "gate keeping" and $ **10:00-12:00** Forms & Utilization Review: • Importance & challenges • Variances • HB services • ERC Tiers **P.M. 1-3:30** • Practice UR • Clinical Eligibility if time **3:30-4:30** Study time, set up provider visits or personnel issues	*Thurs. 8/25/05* **Cyprian Learning Ctr.** **All day - Mary Bolton & Deb Coutu** MDS (assessment) training with Division of Licensing and Protection & nursing home reps	*Fri 8/26/05* **Stanley Hall Rm 107** **A.M. 9:00-11:00 Nancy & Megan** Moderate Group **11:00-2:00 Unit Meeting** (Summer Bash-Pizza & ice cream) **P.M.** Set up provider meetings – review as needed

Week 3				
Mon. 8/29/05 **In the community** (Stanley Hall Rm 107 available) Meet providers	**Tues 8/30/05** **In the community** (Stanley Hall Rm 107 available) Meet providers	*Wed 8/31/05* **Stanley Hall Rm 100** **A.M. 9:00am** **10:00 –11:00-** Theresa Lever - Woodridge NH **11:00-12:30 Nursing Facility setting – Laine Lucenti & Deb Coutu** • Regs, level 1 & 2, providers/contacts/M'care, M'caid, VHAP coverage/complaints. Survey process. Nursing home presenter. • RUGGS triggers • Case Rates • Cost avoid/EDS • Short-term stays • Change report form **P.M. 1:00** Revise Providers Assessments: • ILA/MDS/OASIS • Definitions	**Thurs. 9/1/05** **Stanley Hall Rm 107** **A.M. 9:00** Medicare Advocacy Project (MAP) **1-1:45** Attendant Services Program (ASP) – Mike Meunier **2:00-3:00** Adult Protective Services – Rick Smith	**Fri. 9/2/05** **DCF Computer Lab** (Stanley Hall Rm 100 available) Financial Eligibility: Janet Pare • LTC M'caid • Community M'caid • VHAP basic • Patient Share • Coding • Billing/EDS • ACCESS: to-do message, look up people, add moderate needs if not in system. • Clinical Certification & Change Report

Week 4				
Mon. 9/5/05 **Off - HOLIDAY**	**Tues. 9/6/05** **In the community** Meet providers (Stanley Hall Rm 100 available)	**Wed. 9/7/05** **In the community** Meet providers (Stanley Hall Rm 107 available)	**Thurs. 9/8/05** **Stanley Hall Rm 107** **A.M.** • Denials, Appeals • Complaints • Internal QA **P.M.** • 2:00-3:00 Medicaid Fraud • 3:00-4:00 Ombudsman - Jackie Majoris	*Fri. 9/9/05* **Computer Lab (DCF)** **All day – SAMS** • Data entry • Reports & tracking • (Cyprian Learning Ctr.- Mad Tom Notch available)

Week 5				
Mon. 9/12/05 **Stanley Hall Rm 107** **A.M. 9:00 Legal** – Dena Monahan & Chris Byrom • HIPAA/Confidentiality • POA • Guardianship • Advanced Directives • ADA P.M. 1:00-3:00 Clinical Eligibility - Deb Coutu	**Tues. 9/13/05** **In the community** In the community/office **Waiver Teams:** • Franklin • Orange West Computer Lab available for SAMS practice Cyprian Learning Ctr., Mad Tom Notch available	**Wed. 9/14/05** **In the community** **CMS "Readiness Review"** In the community/office Computer Lab available for SAMS practice	**Thurs. 9/15/05** **In the community** **CMS "Readiness Review"** In the community/office **9/15 Waiver Teams:** • Addison • Windsor Computer Lab available for SAMS practice Cyprian Learning Ctr., Mad Tom Notch available	*Fri. 9/16/05* **In the community** In the community/office **9/16 Waiver Teams:** • Rutland Computer Lab available for SAMS practice

Week 6				
Mon. 9/26/05 Stanley Hall Rm 100 **VIT 1:15-3:15** provider training	**Tues. 9/27/05** **Mad Tom Notch** Open – Pick up files	**Wed. 9/28/05** **Mad Tom Notch** Open – Pick up files **9/28/05 Waiver Team:** Caledonia Waiver	**Thurs. 9/29/05** **Stanley Hall Rm 100** Open – Pick up files	*Fri. 9/30/05* **Stanley Hall Rm 100** PARTY – Open House?

Monday October 3, 2005 – Choices for Care **LIVE!**

Future training:

Aging?Alzheimer's/ Dementia
Challenging Behaviors – Susan Wehry
Out of State
Medicare Modernization Act
Working with Disabilities
PASSAR

Attachment C

Division of Disability and Aging Services
103 South Main Street
Waterbury VT 05671-2301
http://www.dad.state.vt.us/
Telephone (802) 241-2400
TTY (802) 241-3557
Fax (802) 241-2325

August 26, 2005

Medicaid Waiver Participant
Address
Address

Dear Mr./Ms. Name:

Although you will not be affected immediately, the Agency of Human Services wanted you to know that it is changing its long-term care program. The Department of Disabilities, Aging and Independent Living is very pleased to announce the creation of **"Choices for Care"**, a new Vermont Long-Term Care Medicaid program. "Choices for Care" is a research and demonstration program approved by the Centers for Medicare and Medicaid Services (CMS). This new program will start October 1, 2005. The current Home and Community Based Services Waiver Program will expire at that time.

Since you are currently participating in the Home-Based Medicaid Waiver program, the Department will automatically enroll you into the new "Choices for Care" program effective October 1, 2005. Eligibility for you remains the same. **You do not need to take any action at this time**.

Again, no action is required by you at this time. If you have questions about the new program please contact your case manager. If you are unsure of who your case manager is, you can call the Department at 802-241-2400.

Sincerely,

Patrick Flood
Commissioner

Attachment D – Eligibility Criteria, Assessment Procedures & Tools and Level of Care Determination

I. Standards for Eligibility

A. To be eligible for the Choices for Care, VT Long-Term Care Medicaid program an individual must:

1. An eligible individual must be a Vermont resident aged 18 or older who meets both clinical and financial eligibility criteria.

2. Choices for Care shall not replace or supplant services otherwise provided under other 1915c Medicaid waivers or other 1115 Medicaid waivers (e. g. Community Rehabilitation and Treatment). Thus, to be eligible for services other than nursing facility services, an individual must have a functional physical limitation resulting from a physical condition (including stroke, dementia, traumatic brain injury, and similar conditions) or associated with aging. Individuals whose need for services is due to mental retardation, autism, or mental illness shall not be eligible for services.

3. Choices for Care shall not provide or pay for services to meet needs that can be adequately met by services available through other sources. This includes but is not limited to private insurance, Medicaid and Medicare.

NOTE: Individuals choosing a nursing home setting who have an active treatment plan for a mental health diagnosis or developmental disability must have a PASSAR screening completed.

II. Clinical Eligibility

Determination of clinical eligibility is a skilled nursing function conducted by a registered nurse (RN). Accurate clinical assessment requires the consideration of a number of variables that affect an individual's clinical eligibility. In certain cases the attending physician's input will be sought regarding medical conditions. The RN will consider the required variables including medical conditions when making a determination of the individual's clinical eligibility. In addition, the RN may determine that an individual currently enrolled in the Choices for Care program has significantly improved and because of the improvement, no longer meets clinically eligibility criteria. In such an instance, the RN must determine if the individual's condition will worsen if required to leave the program. In other instances, the RN must determine whether an individual is currently receiving adequate services to meet identified needs from other non-waiver sources. If an individual's needs could be met through private and/or other community resources (whether or not they are), the individual will not be eligible for the Choices for Care program.

A. Highest Need Group

Individuals who apply and meet any of the following eligibility criteria shall be eligible for and enrolled in the Highest Needs group:

1. Individuals who require extensive or total assistance with at least one of the following Activities of Daily Living (ADL):
   Toileting Bed mobility

Eating Transferring

AND require *at least* limited assistance with any other ADL.

2. Individuals who have a severe impairment with decision-making skills OR a moderate impairment with decision- making skills AND one of the following behavioral symptoms/conditions, which occurs frequently and is not easily altered:

Wandering
Verbally Aggressive Behavior
Resists Care
Physically Aggressive Behavior
Behavioral Symptoms

3. Individuals who have at least one of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis:

Stage 3 or 4 Skin Ulcers
Ventilator/ Respirator
IV Medications
Naso-gastric Tube Feeding
End Stage Disease
Parenteral Feedings
2nd or 3rd Degree Burns
Suctioning

4. Individuals who have an unstable medical condition that require skilled nursing assessment, monitoring and care on a daily basis related to, but not limited to at least one of the following:

Dehydration
Internal Bleeding

Aphasia
Transfusions
Vomiting
Wound Care
Quadriplegia
Aspirations
Chemotherapy
Oxygen
Septicemia
Pneumonia
Cerebral Palsy
Dialysis
Respiratory Therapy
Multiple Sclerosis
Open Lesions
Tracheotomy
Radiation Therapy
Gastric Tube Feeding

5. Special Circumstances: Individuals who do not meet at least one of the above criteria may be enrolled in the Highest Needs Group when the Department determines that the individual has a critical need for long-term care services due to special circumstances that may adversely affect the individual's safety. The Department may, with the consent of the individual, initiate such an action. An individual may also request such an action. Special circumstances may include:
   a. Loss of primary caregiver (e. g. hospitalization of spouse, death of spouse);
   b. Loss of living situation (e. g. fire, flood);
   c. The individual's health and welfare shall be at imminent risk if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.); or
   d. The individual's health condition would be at imminent risk or worsen if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.).

6. Individuals enrolled in the Highest Needs, High Needs, or Moderate Needs groups who, at reassessment, meet any of these Highest Needs eligibility criteria shall be enrolled in the Highest Needs group.

7. For individuals choosing nursing facility care, the Department shall determine whether the individual is in need of rehabilitation services or long-term care services.

B. High Need Group

Individuals who meet any of the following eligibility criteria shall be eligible for the High Needs group and may be enrolled in the High Needs group:

1. Individuals who require extensive to total assistance on a daily basis with at least one of the following ADLs:
   Bathing Dressing
   Eating Toilet Use
   Physical assistance to walk

2. Individuals who require skilled teaching on a daily basis to regain control of, or function with at least one of, the following:
   Gait training Speech
   Range of motion Bowel or bladder training

3. Individuals who have impaired judgment or impaired decision-making skills that require constant or frequent direction to perform at least one of the following:

   Bathing **Dressing**

   Eating **Toilet Use**
   Transferring Personal hygiene

4. Individuals who exhibit at least one of the following behaviors requiring a controlled environment to maintain safety for self:
   Constant or frequent wandering
   Behavioral Symptoms
   Persistent physically or verbally aggressive behavior

5. Individuals who have a condition or treatment that requires skilled nursing assessment, monitoring, and care on a less than daily basis including (but not limited to) the following:
   Wound Care Suctioning Tube Feedings
   Medication Injections End Stage Disease
   Parenteral Feedings Severe Pain Management

AND who require an aggregate of other services (personal care, nursing care, medical treatments and/or therapies) on a daily basis.

6. Special Circumstances: Individuals who do not meet at least one of the above criteria may be enrolled in the High Needs Group when the Department determines that the individual has a critical need for long-term care services due to one of the following:
   a. Individuals whose health condition shall worsen if services are not provided or if services are discontinued, as determined by the Department, **or**
   b. Individuals whose health and welfare shall be at imminent risk if services are not provided or if services are discontinued, as determined by the Department.

7. Individuals enrolled in the Highest Needs, High Needs, or Moderate Needs groups who, at reassessment, do not meet Highest Needs eligibility criteria but do meet any of these High Needs eligibility criteria shall be enrolled in the High Needs group.

8. For individuals choosing nursing facility care, the Department shall determine whether the individual is in need of rehabilitation services or long-term care services.

C. Transitional Provision

All individuals who are currently being served under a preexisting 1915c Medicaid Waiver (Home-Based or Enhanced Residential Care) or who are receiving Medicaid nursing facility care at the time of the implementation of the Choices for Care waiver shall be enrolled in the Choices for Care waiver and shall continue to receive services. Thereafter, these participants shall continue to be enrolled in Choices for Care if, at reassessment, they meet the eligibility criteria for the Highest Needs group, the High Needs group or the Guidelines for Nursing Home Eligibility adopted in April of 1997.

III. Financial Eligibility

A. Eligibility

To be financially eligible, individuals must meet the existing financial criteria for Vermont Long-Term Care Medicaid as determined by the VT Department for Children and Families (DCF), Economic Services Division (ESD). DCF uses pre-determined income and resource limits, allowing for certain deductions and exclusions.

B. Patient Share

In some cases, individuals may be responsible for paying a portion of their services (patient share), as determined by the Department for Children and Families (DCF). The amount of the patient share, if any, is based on the individual or couple's monthly income after certain allowable deductions. If a patient share is due, DCF will indicate on the written notice the amount of the patient share and the name of the provider to whom the payment is made each month.

C. Coverage

When an individual is found financially eligible for Choices for Care, Long-Term Care Medicaid the State pays for services as determined by the setting. In addition, the individual becomes eligible for all other Vermont Medicaid health benefits including payment for doctors, hospital stays and prescriptions.

D. Estate Recovery

The Office of Vermont Health Access (OVHA) has the legal authority to recover the cost of Choices for Care services that have been provided to the individual and paid for by the State of Vermont. The process of Estate Recovery occurs after the individual has passed away and is accomplished through the probate court process. Existing State and Federal laws determine how and when OVHA may recover costs from an individual's estate.

NOTE: Contact the local DCF office for more information regarding financial eligibility, patient share, health benefits coverage, or estate recovery.

PART 2: VERMONT LONG-TERM CARE CLINICAL ASSESSMENT TOOL

Choices for Care Clinical Assessment

A. ASSESSMENT INFORMATION

1. Date: _____ 2. Interview: ☐Phone, or ☐In Person (where)_____

3. Applicant Name: _____
a. *(Last)* b. *(First)* c. *(M.I.)*

4. Mailing Address (if different from application form):

_____
Street/P.O. Box State Zip

5. Did anyone other than the applicant help answer questions? a. ☐Yes b. ☐No

6. If "Yes", name and relationship of the person(s): _____

B. ACTIVITIES OF DAILY LIVING (ADL's)

Code for individuals actual level of involvement in self-care over 24 hours for the last 7 days.

1. **TOILET USE:** How the individual uses the toilet, commode, bedpan, urinal; transferring on/off toilet, cleansing self, managing incontinence pad(s), managing ostomy or catheter, adjusting clothes.

☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

2. **EATING:** How the individual eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition).

☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

3. **BED MOBILITY:** How the individual moves to and from lying position, turning side-to-side, and positioning body while in bed.

☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times

☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

EXCLUDES to/from /toilet.)
☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

5.**BATHING:** How the individual takes a full-body bath/shower, sponge bath, washing/drying face, hands and perineum. (excluding back and hair)
☐0 - **Independent:** No help provided
☐1 - **Supervision:** Oversight/cueing only
☐2 - **Limited Assist:** Physical help limited to transfer only
☐3 - **Extensive Assist:** Physical help in part of bathing activity
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

6.**DRESSING:** How the individual puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis.
☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

7.**MOBILITY:** How the individual moves between locations in room, outside room and to distant areas of building. If in wheelchair, self-sufficiency once in wheelchair.
☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

8. **PERSONAL HYGIENE:** During the last 7 days, how would you rate the individual's ability to perform personal hygiene? (Combing hair, brushing teeth, shaving, washing/drying face, hands, and perineum, EXCLUDE baths and showers.)

- ☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
- ☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
- ☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
- ☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
- ☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
- ☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

9. **ADAPTIVE DEVICES:** During the last 7 days, how would you rate the individual's ability to manage putting on and removing braces, splints, and other adaptive devices?

- ☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
- ☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
- ☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
- ☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
- ☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
- ☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

10. **MEAL PREPARATION:** During the last 7 days, how would you rate the individual's ability to perform meal preparation? (Planning and preparing light meals or reheating delivered meals.)

- ☐0 - **Independent:** No help provided (With/without assistive devices)
- ☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐2 – **Done by Others**: Full caregiver assistance.
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

11. **MEDICATIONS:** During the last 7 days, how would you rate the individual's ability to manage medications? (Preparing and taking all prescribed and over the counter medications reliably and safely, including the correct dosage at appropriate times/intervals.)

- ☐0 - **Independent:** No help provided (With/without assistive devices)
- ☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐2 – **Done by Others**: Full caregiver assistance.
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

Comments:

NOTE: If no activity scores "Total Dependence" (4) and only one activity scores "Extensive Assist" (3), describe the intensity and frequency of assistance needed in the comments section.

C. COGNITION and MEMORY

1. Memory and use of information:
   A. ☐ Does not have difficulty remembering and using information. Does not require directions or reminding from others.
   B. ☐ Has minimal difficulty remembering and using information. Requires direction and reminding from others 1 to 3 times per day. Does not have to do with memory
   C. ☐ Has difficulty remembering and using information. Requires direction and reminding from others 4 or more times per day.
   D. ☐ Cannot remember or use information. Requires continual verbal reminding.

2. Cognitive Skills for Daily Decision-Making
   A. ☐ Independent – decisions consistent/reasonable
   B. ☐ Modified independence – some difficulty in new situations only
   C. ☐ Moderately impaired – decision poor/cues/supervision required
   D. ☐ Severely impaired – never/rarely makes decisions

Comments:

D. BEHAVIOR SYMPTOMS:

1.a. How often does the individual get lost or wander? (Moves with no rational purpose, seemingly oblivious to needs or safety.) ☐ 0 – Never ☐ 1 – Less than daily ☐ 2 – Daily

1.b. In the last 7 days, was the wandering easily altered?
☐ 0 – Behavior was not present **-OR-** was easily altered ☐ 1 – Behavior was NOT easily altered

2.a. How often is the individual verbally abusive to others? (Others were threatened, screamed at, cursed at.)
☐ 0 – Never ☐ 1 – Less than daily ☐ 2 – Daily

2.b. In the last 7 days, was the verbal abuse easily altered?
☐ 0 – Behavior was not present **-OR-** was easily altered ☐ 1 – Behavior was NOT easily altered

3.a. How often is the individual physically abusive to others? (Others were hit, shoved, scratched, sexually abused.)
☐ 0 – Never ☐ 1 – Less than daily ☐ 2 – Daily

3.b. In the last 7 days, was the physical abuse easily altered?
☐ 0 – Behavior was not present **-OR-** was easily altered ☐ 1 – Behavior was NOT easily altered

4.a. How often does the individual exhibit socially inappropriate/disruptive behavior? (Makes disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings.)
☐ 0 – Never ☐ 1 – Less than daily ☐ 2 – Daily

4.b. In the last 7 days, was the socially disruptive behavior easily altered?
☐ 0 – Behavior was not present **-OR-** was easily altered ☐ 1 – Behavior was NOT easily altered

5.a. How often did the individual display symptoms of resisting care? (Resists taking medications/injections, ADL assistance, or eating.)

☐0 – Never ☐1 – Less than daily ☐2 – Daily

5.b. In the last 7 days, was the resisting care behavior easily altered?

☐0 – Behavior was not present **-OR-** was easily altered ☐1 – Behavior was NOT easily altered

F. MEDICAL INFORMATION

1. **Medical Diagnosis:** List only current medical conditions for which the individual is receiving services/treatments.

_____

_____

2. **Disease Diagnosis:** *Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses.)*

A. ☐Aphasia
B. ☐Cerebral palsy
C. ☐Dementia other than Alzheimer's disease
D. ☐Multiple sclerosis
E. ☐Quadriplegia
F. ☐Traumatic brain injury
G. ☐Emphysema/COPD
H. ☐Renal failure
I. ☐OTHER-List:
J. ☐OTHER-List:
K. ☐NONE OF THE ABOVE

3. **Infections:** *Check all that apply*. If none apply, check the NONE OF THE ABOVE box.

A. ☐Pneumonia
B. ☐Respiratory infection
C. ☐Septicemia
D. ☐OTHER-List:
E. ☐OTHER-List:
F. ☐NONE OF THE ABOVE

4. **Problem Conditions:** *Check all problems present in the last 7 days.*

A. ☐Dehydration
B. ☐Dizziness/Vertigo
C. ☐Recurrent lung aspirations ***in last 90 days***
D. ☐Shortness of breath
E. ☐Syncope (fainting)
F. ☐**Unsteady gait**
G. ☐End stage disease, 6 or fewer months to live
H. ☐OTHER-List:
I. ☐OTHER-List:
J. ☐NONE OF THE ABOVE

5. **Special Care/Treatments:** *Check all treatments received during the last 14 days*.

A. ☐Chemotherapy
B. ☐Dialysis
C. ☐IV meds
D. ☐Oxygen therapy
E. ☐Radiation
F. ☐OTHER-List:
G. ☐OTHER-List:
H. ☐NONE OF THE ABOVE

6.a. **Therapies:** *Check all therapies received in last 7 days.*

A. ☐Speech Therapy
B. ☐Occupational Therapy
C. ☐Physical Therapy
D. ☐Respiratory Therapy
E. ☐NONE OF THE ABOVE

6.b. Does the individual currently receive at least 15minutes/day of PT, ST RT or OT or a combination of that equals skilled teaching on a daily basis.?

A. ☐Yes B. ☐No C. ☐info. unavailable

7. **Nutrition:** Check all nutritional issues in the last 7 days. *(Mark all that apply)*

A. ☐Parenteral/IV
B. ☐Feeding tube
C. ☐OTHER: List
D. ☐OTHER-List:
E. ☐NONE OF THE ABOVE

8.a. **Pain Status:** What is the frequency of pain interfering with individual's activity or movement? C*heck one.*

A. ☐Individual has **no** pain or pain does **not** interfere with activity or movement
B. ☐Less often than daily
C. ☐Daily, but not constantly
D. ☐All of the time
E. ☐Info. unavailable

8.b. Is the individual experiencing pain that is not easily relieved, occurs at least daily, and affects the individual's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity? A. ☐Yes B. ☐No C. ☐info unavailable

9.a. **Ulcers:** Record the number of ulcers (due to any cause) at each ulcer stage on any part of the body. Specify "0" if no pressure ulcer(s).

A. **Stage 1**: ____ A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
B. **Stage 2**: ____ A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
C. **Stage 3**: ____ A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.
D. **Stage 4**: ____ A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

9.b. Indicate which of the following skin problems the individual has that requires treatment. *Check all that apply during last 7 days.*

A. ☐Burns (second or third)
B. ☐Open lesions other than ulcers, rashes, cuts (e.g. cancer lesions)
C. ☐Surgical wounds
D. ☐NONE OF THE ABOVE

10.a. **Urinary Status:** Does the individual have urinary incontinence?

A. ☐ Yes
B. ☐ No incontinence and no urinary catheter
C. ☐ No incontinence, individual has urinary catheter

If answer is B. or C., go to question #11.a.

10.b. What is the frequency of urinary incontinence?

A. ☐ less than once weekly
B. ☐ one to three times weekly
C. ☐ four to six times weekly
D. ☐ one to three times daily
E. ☐ four or more times daily

10.c. When does urinary incontinence occur?

A. ☐ during the day only B. ☐ during the night only C. ☐ during the day and night

11.a.. **Bowel Status:** Does the individual have bowel incontinence?

A. ☐ Yes
B. ☐ No incontinence and no ostomy
C. ☐ No incontinence, individual has an ostomy
If answer is B. or C., skip 11.b and 11.c.

11.b. What is the frequency of bowel incontinence?

A. ☐ less than once weekly
B. ☐ one to three times weekly
C. ☐ four to six times weekly
D. ☐ one to three times daily
E. ☐ four or more times daily

11.c. When does bowel incontinence occur?

A. ☐ during the day only B. ☐ during the night only C. ☐ during the day and night

Comments_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DAIL LTCCC signature: _____ Date: _____

KEY: Activities of Daily Living (ADL), Self-Performance

0 = Independent – No help or oversight **–OR-** help/oversight provided only 1 or 2 times during the last seven days.

1 = Supervision – Oversight, encouragement or cueing provided 3 or more times**—OR—** Supervision (3 or more times) plus limited physical assistance provided only 1 or 2 times during the last seven days.

2 = Limited Assistance – Individual highly involved in activity, received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3 or more times**—OR—**Limited assistance (3 or more times) plus extensive assistance provided only 1 or 2 times in the last 7 days.

3 = Extensive Assistance – While individual performed part of activity, weight-bearing support or full caregiver performance 3 or more times over part (but not all) of the last seven days.

4 = Total Dependence –Full caregiver performance of the activity each time the activity occurred during the entire seven-day period. There is complete non-participation by the individual in all aspects of the ADL definition task. If the caregiver performed an activity for the individual during the entire observation period, but the individual performed part of an activity him/herself, it would NOT be coded as a "4" Total Dependence.

BATHING Self-Performance Key– Due to the nature and frequency of the bathing activity, the following self-performance scale is used.

0 = Independent – No help or oversight provided.

1 = Supervision – Oversight, encouragement or cueing only.

2 = Limited Assistance – Individual highly involved in activity, received physical help to transfer only.

3 = Extensive Assistance – While individual performed part of activity, physical help in part of the activity was provided.

4 = Total Dependence –Full caregiver performance of the activity each time the activity occurred during the entire seven-day period. There is complete non-participation by the individual in all aspects of the ADL definition task. If the caregiver performed an activity for the individual during the entire observation period, but the individual performed part of an activity him/herself, it would NOT be coded as a "4" Total Dependence.

I. Initial Assessment Procedures

After the Department of Aging and Independent Living (DAIL) staff determines clinical eligibility and sends Clinical Authorization to DCF and providers, a comprehensive assessment must be completed in order to develop a Service Plan for ongoing Long-Term Care Medicaid (LTCM) services. The assessment procedure is determined by the following LTCM settings:

A. Home-Based Initial Assessment

1. **Case manager**, together with the individual, shall complete a full assessment (ILA) within 14 calendar days of receipt of the Clinical Authorization.

2. The **case manager** shall ensure that a registered nurse completes the Health Assessment portion of the ILA.

3. The **case manager**, together with the individual, shall assess the individual's circumstances, resources, strengths and needs.

4. The **case manager**, together with the individual, shall identify the service options which will address the individual's unmet needs and for which the individual is eligible.

5. The **case manager**, together with the individual, shall identify, if any, the informal/family supports that will continue.

6. The **case manager**, together with the individual, shall review the service options and service limitations with the individual, surrogate, and/or guardian.

7. The **case manager**, together with the individual shall select services and develop a comprehensive Service Plan with the individual that is appropriate to the identified needs, and in compliance with existing LTCM service definitions, standards, procedures, and limitations.

8. The **case manager** shall obtain the signature of the applicant and surrogate (when applicable) on the Service Plan.

9. The **case manager** shall sign the Service Plan.

10. The **case manager** shall review and complete an "In-Home Back-up Care & Emergency Plan" form with the individual. The plan shall be posted in an obvious location within the individual's home.

11. The **case manager** shall compile and submit a complete assessment package to DAIL.

12. The **case manager** shall ensure that the package is complete, containing the following documents:
    a. Proposed Service Plan
    b. Personal Care Worksheet

c. Independent Living Assessment (ILA)
d. Permission for Release of Information
e. Assistive Devices and Modifications Addendum (if applicable)
f. Employer Certification Form (if applicable for consumer/surrogate-directed only)
g. Variance request(s) (if applicable)
h. Adult Family Care Agreement (if applicable)

13. **DAIL staff** shall return incomplete initial assessment packets to the case manager.

14. The **case manager** shall assist the applicant with the VT Long-Term Care Medicaid (LTCM) financial eligibility application when necessary. The Department for Children and Families (DCF) financial eligibility forms shall be completed as soon as possible after Clinical Certification has been made.

15. The **case manager** shall distribute a copy of the Personal Care Worksheet to the personal care attendant (PCA) employer (Home Health Agency, surrogate, or consumer).

16. The **case manager** and **providers** shall follow procedures for "Initiating Services".

17. **DAIL staff** shall complete Utilization Review (UR).

18. The **Department for Children and Families (DCF)** shall complete LTCM financial eligibility and send notice to individual, provider and DAIL.

19. **DAIL staff** shall verify LTCM financial eligibility.

20. If the individual meets the financial eligibility criteria, **DAIL staff** shall authorize the initial Service Plan, including any adjustments as determined in the UR process.

21. **DAIL staff** shall mail approved Service Plan to the individual, case manager and providers.

22. **DCF staff** shall mail a denial letter with appeal rights, to individuals do not meet the LTCM financial eligibility criteria. A copy of the denial notice will be send to DAIL staff.

23. Enter the appropriate "requested start date" on the Plan of Care. This must be the **latest** of the following:
    - the date the individual signed an application
    - the date the individual was assigned a slot by the DAA
    - the date the Plan of Care was developed and signed
    - the date the individual became eligible for Long-Term Medicaid

24. send a copy of the ILA to the local Utilization Review (UR) nurse for level of care review;

B. Enhanced Residential Care (ERC) Initial Assessment

1. The **ERC provider**, together with the individual, must complete a full assessment (RCHRAT) within 14 calendar days of admission, together with the case manager whenever possible.

2. The **ERC provider** shall ensure that a registered nurse completes or signs-off on the assessment.

3. The **Licensed Level III Residential Care Home** that is an ERC provider must submit a variance request to the Division of Licensing and Protection (DLP) for permission to serve or retain the individual.

4. The **ERC provider** shall provide a copy of the RCHRAT to the case manager.

5. The **case manager** shall complete an ERC Tier worksheet and ERC Service Plan.

6. The **case manager** shall obtain the signature of the applicant or legal representative on the Service Plan.

7. The **case manager** shall sign the Service Plan.

8. The **case manager** shall compile and submit a complete assessment package to DAIL.

9. The **case manager** shall ensure that the package is complete and contains the following documents:
   a. Proposed Service Plan
   b. Tier Worksheet
   c. Residential Care Home Resident Assessment Tool (RCHRAT)
   d. Permission for Release of Information
   e. Written Justification for Dual Participation in Hospice (if applicable)
   f. Variance Request Form (when applicable)

10. **DAIL** shall return incomplete initial assessment packets to the case manager.

11. The **case manager** shall assist the applicant with the VT Long-Term Care Medicaid financial eligibility application when necessary. The Department for Children and Families (DCF) financial eligibility forms shall be completed as soon as possible after Clinical Certification has been made.

12. **DAIL** shall complete Utilization Review (UR).

13. **DLP** shall send a copy of the variance approval to DAIL (*Licensed Level III only*).

14. The **Department for Children and Families** (DCF) shall complete LTC Medicaid financial eligibility and send notice to individual, provider and DAIL.

15. **DAIL** shall verify LTCM financial eligibility and DLP variance status.

16. **DAIL** shall authorize the initial Service Plan, including any adjustments as determined in UR process.

17. **DAIL** shall mail approved Service Plan to the individual, case manager and providers.

18. **DCF staff** shall mail a denial letter with appeal rights to individuals who do not meet the LTCM financial eligibility criteria. A copy of the denial notice will be send to DAIL staff.

19. **DAIL** shall send a denial letter with appeal rights to individuals who are denied a variance by DLP.

20. The **ERC provider** shall follow procedures for “Initiating Services”.

C. Nursing Facility (NF) Initial Assessment

1. The **NF provider**, together with the individual, shall complete the Minimum Data Set (MDS) according to existing State and Federal nursing facility regulation.

2. The **NF provider** shall assist the applicant with the VT Long-Term Care Medicaid (LTCM) financial eligibility application when necessary. The Department for Children and Families (DCF) financial eligibility forms shall be completed as soon as possible after Clinical Certification has been made.

3. The **Department for Children and Families** (DCF) shall complete LTCM financial eligibility and send notice to individual, NF provider and DAIL.

4. The **NF provider** shall follow procedures for “Initiating Services”.

5. **DCF staff** shall mail a denial letter with appeal rights to individuals do not meet the LTC Medicaid financial eligibility criteria. A copy of the denial notice will be send to DAIL staff and NF provider.

II. Reassessments Procedures

Individuals participating in Long-Term Care Medicaid services must have a comprehensive reassessment completed on a regular basis. The reassessment procedure is determined by the following LTCM settings:

A. Home-Based Reassessment

1. The **case manager**, together with the individual, shall complete a full reassessment (ILA) at least once every 365 days. The reassessment must be completed, submitted and received at DAIL prior to the previous plan of care end date.

2. The **case manager**, together with the individual, shall assess the individual’s circumstances, resources, strengths and needs.

3. The **case manager**, together with the individual, shall identify the service options which will address the individual’s unmet needs and for which the individual is eligible.

4. The **case manager** shall identify, if any, the informal/family supports that will continue.

5. The **case manager** shall review the service options and service limitations with the individual, surrogate, and/or guardian.

6. The **case manager**, together with the individual, shall select services and develop a comprehensive Service Plan with the individual that is appropriate to the identified needs, and in compliance with existing LTCM service definitions, standards, procedures, and limitations.

7. The **case manager** shall ensure that a registered nurse completes the Health Assessment portion of the ILA.

8. The **case manager** shall obtain the signature of the applicant and surrogate (when applicable) on the Service Plan.

9. The **case manager** shall sign the Service Plan.

10. The **case manager** shall compile and submit a complete reassessment package to DAIL.

11. The **case manager** shall ensure that the package is complete, containing the following documents:
    a. Proposed Service Plan
    b. Personal Care Worksheet
    c. Independent Living Assessment (ILA)
    d. Permission for Release of Information
    e. Assistive Devices and Modifications Addendum (if applicable)
    f. Employer Certification Form (if applicable for consumer/surrogate-directed only)
    g. Variance request(s) (when applicable)
    h. Adult Family Care Agreement (if new or different)

12. **DAIL staff** shall return incomplete reassessment packets to the case manager

13. The **case manager** shall assist the applicant with the VT Long-Term Care Medicaid (LTCM) financial eligibility reviews when necessary.

14. The **case manager** shall distribute a copy of the Personal Care Worksheet to the personal care attendant (PCA) employer (Home Health Agency, surrogate, or consumer).

15. **DAIL staff** shall complete Utilization Review (UR).

16. **DAIL staff** shall authorize the Service Plan, including any adjustments as determined in UR process.

17. **DAIL staff** shall mail approved Service Plan to the individual, case manager and providers.

B. Enhanced Residential Care (ERC) Reassessment

1. The **ERC provider**, together with the individual, must complete a comprehensive reassessment (RCHRAT) at least once every 365 days, together with the case manager whenever possible. The reassessment must be completed, submitted and received at DAIL prior to the previous plan of care end date.

2. The **ERC provider**, together with the individual, shall assess the individual's circumstances, resources, strengths and needs.

3. The **ERC provider** shall ensure that a registered nurse completes or signs-off on the reassessment.

4. The **ERC provider** shall provide a copy of the RCHRAT to the case manager.
5. The **case manager** shall complete an ERC Tier worksheet and ERC Service Plan.

6. The **case manager** shall obtain the signature of the applicant or legal representative on the Service Plan.

7. The **case manager** shall sign the Service Plan.

8. The **case manager** shall compile and submit a complete reassessment package to DAIL.

9. The **case manager** shall ensure that the package is complete, containing the following documents:
   a. Proposed Service Plan
   b. Tier Worksheet
   c. Residential Care Home Resident Assessment Tool (RCHRAT)
   d. Permission for Release of Information

10. **DAIL staff** shall return incomplete reassessment packets to the case manager.

11. The **case manager** shall assist the applicant with the VT Long-Term Care Medicaid (LTCM) financial eligibility reviews when necessary.

12. **DAIL staff** shall complete Utilization Review (UR).

13. **DAIL staff** shall authorize the Service Plan, including any adjustments as determined in UR process.

14. **DAIL staff** shall mail approved Service Plan to the individual, case manager and providers.

C. Nursing Facility (NF) Reassessment

1. The **NF provider**, together with the individual, shall complete the Minimum Data Set (MDS) according to existing NF regulation.

2. The **NF provider** shall assess the individual's circumstances, resources, strengths and needs.

3. The **NF provider** shall assist the applicant with the VT Long-Term Care Medicaid (LTCM) financial eligibility review when necessary.

III. Dual Program Participation Assessment Procedures

Attendant Services Program

Only individuals granted a variance by DAIL may participate in both LTCM services and the Attendant Services Program (ASP). If DAIL approves the individual to participate in both programs, the following assessment procedures apply:

1. The **case manager** shall coordinate and complete assessments together with the State RN assessor for the ASP.

2. The **State ASP assessor** shall complete the Health and Functional Assessment sections of the Independent Living Assessment (ILA) and a dual participation Personal Care Worksheet.

4. The **case manager** shall complete the LTCM Service Plan to include the personal care hours from the Personal Care Worksheet as completed by the **State ASP assessor**, as well as all other necessary LTCM forms.

5. The **case manager** must contact the State RN assessor prior to any plan of care change to determine whether a dual assessment is necessary.

6. The **State ASP assessor** shall ensure that a copy of the ILA assessment is forwarded to the case manager immediately upon completion.

7. Once the ILA is received, the **case manager** will follow the process for submitting complete assessment packets to DAIL.

8. **DAIL staff** shall complete utilization review and clinical eligibility determinations.

9. **DAIL staff** shall authorize the Service Plan in coordination with the State ASP assessor and ASP review committee.

Behavior Definitions
(MDS Manual 2002, Chapter 3, page 3-66 and 3-67)

a. **Wandering:** Locomotion with no discernible, rational purpose. A wandering resident may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g. a hungry person moving about the unit in search of food). Wandering may be manifested by walking or by wheelchair.

   Do not include pacing as wandering behavior. Pacing back and forth is not considered wandering.

b. **Verbally Abusive Behavioral Symptoms**: Other residents or staff were threatened, screamed at, or cursed at.

c. **Physically Abusive Behavioral Symptoms**: Other residents or staff were hit, shoved, scratched, or sexually abused.

d. **Socially Inappropriate/Disruptive Behavioral Symptoms**: Includes disruptive sounds, excessive noise, screams, self-abusive acts, or sexual behavior or disrobing in public, smearing or throwing food or feces, hoarding, rummaging through others' belongings.

e. **Resists Care:** Resists taking medications/injections, ADL assistance or help with eating. This category does not include instances where the resident has made an informed choice not to follow a course of care (e.g., resident has exercised his or her right to refuse treatment, and reacts negatively as staff try to reinstitute treatment).

Signs of resistance may be verbal and/or physical (e.g., verbally refusing care, pushing caregiver away, scratching caregiver). These behaviors are not necessarily positive or negative, but are intended to provide information about the resident's responses to nursing interventions and to prompt further investigation of causes for care planning purposes (e.g., fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness for greater participation in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided.)

Category: ☐HIGHEST ☐HIGH

Clinical Eligibility Worksheet (Choices for Care)

Name: _____

NOTE: Steps 2-6 indicate HIGHEST Need criteria. Steps 7-11 indicate HIGH Need criteria.

STEP 1. Pre-eligibility Screening

1. Is the applicant a Vermont resident and age 18 or over? ☐Yes ☐No **IF NO, STOP.**

2. Can the needs of the individuals be adequately met by services available through other sources (including but not limited to trusts, contracts for care, private insurance, Medicare, Community Medicaid, VA, VHAP, etc)? ☐Yes ☐No **IF YES, STOP.**

3. HB or ERC setting only: Does the individual have a functional limitation resulting from a physical condition (including stroke, dementia, traumatic brain injury, and similar conditions) or associated with aging?
☐N/A ☐Yes ☐No **If NO, STOP**.

4. NF setting only: If the individual has an active mental health or developmental disabilities treatment plan, have they "passed" a PASSAR screening?
☐N/A ☐Yes ☐No **If NO, STOP.**

STEP 2. Late Loss ADL's: Toileting, Eating, Bed Mobility or Transfer = **3 or 4 AND** any other ADL= **2** or greater

YES ☐- **Eligible: HIGHEST Need Group** **NO** ☐-Continue

STEP 3. Cognition: Decision making skills severely impaired. (**B4= 3 severe)**

YES ☐- **Eligible: HIGHEST Need Group** **NO** ☐-Continue

STEP 4. Cog & Behavior: Decision making skills mod. impaired (**B4= 2 moderate) AND** a behavior not easily altered.

__Wandering (**E4ab=1**) __Physical Abuse (**E4cb=1**) __Resist Care (**E4eb=1**)
__Verbal Abuse (**E4bb=1**) __Inappropriate Behavior (**E4db=1**)

YES ☐- **Eligible: HIGHEST Need Group** **NO** ☐-Continue

STEP 5. Conditions/Treatments

Does the individual have any of following conditions or treatments that requires skilled nursing on a **daily basis**?

__End Stage Disease (**J5c=1**) __Stage 3 or 4 Skin Ulcers (**M1c or M1d>0**) __Suctioning (**P1ai=1**)
__Parenteral Feedings (**K5a=1**) __2nd or 3rd Degree Burns (**M4b=1**) __Ventilator/Respirator (**P1al=1**)
__Naso-gastric Tube Feeding (**K5b=1**) __IV Medications (**P1ac=1**)

YES ☐- **Eligible: HIGHEST Need Group** **NO** ☐-Continue

STEP 6. Unstable Medical Conditions

Does the individual have an **unstable medical condition** which requires skilled nursing on a **daily basis** related to but not limited to the following conditions?

__Aphasia (**I1r**) __Internal Bleeding (**J1j**) __Dialysis **(P1ab**)
__Cerebral Palsy (**I1s**) __Aspirations **(J1k**) __Oxygen Therapy (**P1ag**)

__Multiple Scelerosis (**I1w**)
__Quadriplegia (**I1z**)
__Pneumonia (**I2e**)
__Septicemia (**I2g**)
__Dehydration (**J1c**)
__Vomiting **(J1o**)
__Gastric Tube Feeding **(K5b**)
__Open Lesions (**M4c**)
__Wounds (**M5f**)
__Chemotherapy (**P1aa**)
__OTHER:_____
__Radiation Therapy (**P1ah**)
__Tracheostomy (**P1aj**)
__Transfusions (**P1ak**)
__Respiratory Therapy (**P1bda**)

YES ☐- **Eligible: HIGHEST Need Group** **NO** ☐- Continue to High Need Group Worksheet

OTHER: Does the individual meet the **HIGHEST Need** criteria for reasons other than above?

YES ☐- **Eligible HIGHEST Need Group** **NO** ☐-Continue *If YES, use comment space on back to explain.*

Step 7. Non-Late Loss ADL's: Bathing, Dressing, Eating, Toileting , Physical Assistance to Walk = **3 or 4**

YES ☐- **Eligible: HIGH Need Group** **NO** ☐-Continue

Step 8. Skilled Teaching
Does the individual require skilled teaching (rehab) on a daily basis: gait training, speech, range of motion, bowel and/or bladder program **(H3b=1)**

YES ☐- **Eligible: HIGH Need Group** **NO** ☐-Continue

Step 9. Cognition & Cueing

Impaired judgment or decision making skills =**Moderate** or impaired judgment **(B4= 2)** that requires constant or frequent re-direction for bathing, dressing, eating, toileting, transferring or personal hygiene.

YES ☐- **Eligible: HIGH Need Group** **NO** ☐-Continue

Step 10. Behaviors
Does the individual exhibit one of the following behaviors that requires a controlled environment to maintain safety for self?
__Wandering (E4aA=2 or 3)
__Verbally abusive (E4bA=2 or 3)
__Physically Abusive (E4cA=2 or 3)
__Socially Inappropriate Behavior (E4dA=2 or 3)

YES ☐- **Eligible: HIGH Need Group** **NO** ☐-Continue

Step 11. Conditions/Treatment & Aggregate Daily Services
Does the individual have a condition or treatment that requires skilled nursing assessment, monitoring and care on a less than daily basis such as (but not limited to):
__Severe Pain Management (**J2a=1 and J2b=3**)
__End Stage Disease (**J5c=1**)
__Parenteral Feedings (**K5a=1**)
__Wound Care (**M5f=1)**
__Medication Injections (**O3>0 but <7**)
__Suctioning (**P1ai=1**)
__OTHER: _____

-AND-

An aggregate of other services (personal care, nursing care, medical treatments or therapies) adding up to 7 days a week.

YES ☐- **Eligible: HIGH Need Group** **NO** ☐-**NOT Eligible**

OTHER: Does the individual meet the **HIGH Need** criteria for reasons other than above?

YES ☐- **Eligible HIGH Need Group** **NO** ☐-Ineligible

Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
__

DAIL LTCCC Signature:_____
Date:_____

Date of Follow Up if Necessary: _____

VERMONT CHOICES FOR CARE APPLICATION FOR "MODERATE NEEDS" SERVICES

Choices for Care

Moderate Needs Group Application for Services

To be completed by homemaker or adult day provider.

Please Print Clearly

SECTION A: Individual Information

1. Name: _____ 2. ☐ Male ☐ Female

Last *First* *MI*

3. Mailing Address: _____

Street/RFD/Box *City/Town* *State* *Zip*

4. Phone: _____ 5. SS #: _____ 6. Date of Birth: ____/____/_____

7. Does this individual participate in Housing and Supportive Services (HASS)? ☐ Yes ☐ No ☐ Don't Know

SECTION B: Moderate Needs Services

Indicate the services the individual is applying for, the provider of those services and plan for hours per week:

☐ Adult Day Services: _____

☐ Homemaker Services: _____

SECTION C: Choice of Case Management Agency *(Non-HASS Only)*

You must choose one of the below agencies to provide case management services if you are found eligible. The case manager will assist with the ongoing service coordination.

☐ Area Agency on Aging ***-OR-*** ☐ Home Health Agency

SECTION D: Person/Agency Completing Form

Person Completing Form: _____

Agency Name: _____ Phone Number: _____

Signature: _____ Date: _____

By signing this application form, the individual/legal representative agrees to the following statements:

- I understand that my name may be placed on a waiting list and I will be notified if this is the case.
- I agree to provide medical and financial information to the persons who will determine my eligibility and provide services.
- I agree that all medical and financial information I provide is true the best of my knowledge.
- I give permission for the Department of Disabilities, Aging and Independent Living staff to contact my legal representative (if applicable) and the agencies and medical providers I am currently involved with in order to determine eligibility and to eliminate duplication of effort.

- I understand that I must meet the general, clinical and financial eligibility criteria to be eligible for VT Long-Term Care Medicaid "Moderate Needs" services.
- I understand that if found ineligible for Long-Term Care Medicaid services, I will be informed of my appeal rights.
- I understand that Case Management services are limited to a maximum of 12 hours per calendar year.
- I understand that Homemaker services are limited to a maximum of 6 hours per week.
- I understand that Adult Day services are limited to a maximum of 30 hours per week.
- **To the best of my knowledge, the information on this form is correct.**

Applicant/Legal Representative_____

_____

Signature *Date*

Mail or FAX application with assessment, permission for release of information, clinical and financial worksheets to regional DAIL staff.

Mail or Fax to: DAIL, Long-Term Care Clinical Coordinator *(address below)*

DAIL District Office	Address	Phone Number	FAX
Barre	Mcfarland State Office Building 5 Perry St., Suite 150 Barre, VT 05641	(802) 476-1646	(802) 476-1654
Bennington	200 Veterans' Memorial Drive, Suite 6 Bennington, VT 05201	(802) 447-2850	(802) 447-6972
Brattleboro	232 Main Street PO Box 70 Brattleboro, VT 05302-0070	(802) 257-2820 *(main line)*	(802) 254-6394
Burlington	312 Hurricane Lane Suite 201 Williston, VT 05495	(802) 879-5900 *(main line)*	(802) 879-5919
Hartford	State Office Building/ESD 100 Mineral Street, Suite 201 Springfield, VT 05156 *(temporary address)*	(802) 885-8875 *(temporary)*	(802) 885-8879 *(temporary)*
Middlebury	700 Exchange Street Middlebury, VT 05753	(802) 388-3146	(802) 388-4637
Morrisville	63 Professional Drive, Suite 4 Morrisville, VT 05661	(802) 888-4291	(802) 888-1345
Newport	100 Main St., Suite 240 Newport, VT	(802) 334-3910	(802) 334-3386
Rutland	320 Asa Bloomer Building Rutland, VT 05701	(802) 786-5971	(802) 786-5882
Springfield	State Office Building/ESD 100 Mineral Street, Suite 201 Springfield, VT 05156	(802) 885-8875	(802) 885-8879
St. Albans	20 Houghton Street, Suite 313 St. Albans, VT 05475	(802) 524-7913	(802) 527-5403
St. Johnsbury	67 Eastern Ave, Suite 7 St. Johnsbury, VT 05819	(802) 748-8361	(802) 751-3272

Moderate Needs Group Financial Worksheet (Information is self-reported by the individual or legal rep.)

Individual Name: _____ Date: _____

STEP 1. Resources: (Include only "liquid" assets that are easily convertible into cash.)

	Individual	Spouse
Cash:	$	$
Savings:	$	$
Checking:	$	$
CD's:	$	$
Money Market:	$	$
Stocks/Bonds:	$	$
trusts:	$	$
Other:	$	$
Subtotal:	**$**	**$**
Total Combined Resources:	**$**	

If the Total Combined Resources are **equal to or less than $10,000**, then continue to STEP 2.

If the Total Combined Resources are more than $10,000, then the individual is **NOT eligible**.

STEP 2. Gross Monthly Income:

	Individual	Spouse
Social Security	$	$
SSI	$	$
Retirement/Pension	$	$
Interest	$	$
VA Benefits	$	$
Wages/Salaries/Earnings	$	$
Other (i.e. rental income)	$	$
Subtotal:	**$**	**$**
Total Gross Monthly Income:	**$**	

STEP 3. Monthly Medical Expenses (Divide one-time medical bills by 12.)

	Individual	Spouse
Prescriptions:	$	$
Over-the-counter medications:	$	$
Physician Bills:	$	$
Hospital Bills:	$	$
Health Ins Premiums (Medicare, BCBS, etc):	$	$
Therapy (OT/PT/ST):	$	$
Medical Equipment and Supplies:	$	$
Other (explain):	$	$
Subtotal:	**$**	**$**
Total Monthly Medical Expenses:	**$**	

STEP 4. Adjusted Monthly Income

Total Gross Monthly Income (above):	$
	minus (-)
Monthly Medical Expenses (above):	$
****Adjusted Monthly Income***	**$**

Financially eligible if "Adjusted Monthly Income" is at or below 300% SSI rate (2005).

Individual = **$ 1,737.00** Couple = **$ 2,607.00**

Form Completed by: _____

Vermont Choices for Care
Moderate Needs Group-Clinical Eligibility Worksheet

Information may be gathered from current assessment (ILA) or directly from the individual, legal representative or provider(s).

Step 1.
Individual has passed the pre-eligibility screening questions.

YES ☐- If Yes, Continue **NO** ☐- **If No, STOP – Not Eligible**

Step 2.
Does the individual require supervision or any physical assistance three (3) or more times in seven (7) days with any single, or combination of, ADLs or IADLs?

YES ☐- **Eligible: Moderate Need Group** **NO** ☐-Continue

Step 3.
Does the individual have impaired judgment or decision making skills that require general supervision on a daily basis?

YES ☐- **Eligible: Moderate Need Group** **NO** ☐-Continue

Step 4.
Does the individual require at least monthly monitoring for a chronic health condition?

YES ☐- **Eligible: Moderate Need Group** **NO** ☐-Continue

Step 5.
Will the individual's health condition worsen if services (adult day, homemaker or case management) are not provided or if services are discontinued?

YES ☐- **Eligible: Moderate Need Group** **NO** ☐-**NOT eligible**

Comments:

NOTE:
If the individual does not meet the clinical criteria, send a denial letter with appeal rights.
If the individual is found clinically eligible, complete the financial worksheet to determine financial eligibility.

"CHOICES FOR CARE," VT LONG-TERM CARE MEDICAID APPLICATION FORM

Please Print Clearly

SECTION A: Individual Information

1. Name: _____
Last *First* *MI*

2. ☐ Male ☐ Female

3. Address _____
Street/RFD/Box *City/Town* *State* *Zip*

4. Phone: _____ 5. SS #: _____

6. Date of Birth: ____/____/_____

7. Town where services will be provided, if different than current residence: _____

8. Currently at: ☐ Home ☐ Hospital ☐ Nursing Home

☐ Residential Care Home/ALR

Name of facility:_____

SECTION B: Contact Information

1. Spouse/Partner (if any):

_____
a. (Name) *b. (Phone)*

2. Primary Physician:

_____
a. (Name) *b. (Phone)*

3. Other contact (family/friend):

_____
a. (Name) *b. (Phone)*

4. Legal Representative (if any): _____ Phone: _____
Address:_____
Street/RFD/Box *City/Town* *State* *Zip*

* Type of legal representative: _____ ***(Attach copy of documentation if available.)***

SECTION C: Choice of Care/Setting

1. Where do you (or legal representative) want to receive your long-term care services?
   a. ☐Own home/apartment c. ☐Nursing Home e. ☐No preference
   b. ☐Home of another (family, friend) d. ☐Enhanced Residential Care provider

2. If other than "own home/apartment" indicate the name and phone number of the planned place of residence.
Name: _____ Phone number: _____

3. Would the individual like someone to contact them regarding additional long-term care choices and program options? ☐Yes ☐No

SECTION D: Health Benefits

1. Do you have any of the following health benefits?

a. Medicare	☐Yes	☐No	☐Don't know
b. VT Medicaid	☐Yes	☐No	☐Don't know
c. VT Health Access Plan (VHAP)	☐Yes	☐No	☐Don't know
d. Veterans (VA) Medical	☐Yes	☐No	☐Don't know
e. Private Health Insurance	☐Yes	☐No	☐Don't know

2. If under 65 years of age, do you have a disability? ☐Yes ☐No
If "Yes", describe:
_____

SECTION E: Risk Factors

Check **all** of the following that apply:
a. ☐ Multiple hospital admissions (3 or more) in last 6 months
b. ☐ Multiple Emergency Room visits (3 or more) in last 6 months.
c. ☐ Fallen more than once in the last month. *Number of falls:*_____
d. ☐ Takes 5-7 prescription medications. *Number of medications:*_____
e. ☐ Takes 8 or more prescription medications. *Number of medications:*_____
f. ☐ Primary caregiver is expressing burnout or is at risk of imminent harm, ill health, or loss of job
g. ☐ Recent loss (past 3 months) of primary caregiver
h. ☐ No informal (unpaid) caregivers, such as family/friends
i. ☐ None of the above

SECTION F: Current Agency/Program Involvement

1. Check all agencies that you are currently involved with and indicate the name of the agency:
a. ☐Agency on Aging: _____
b. ☐Home Health Agency:_____
c. ☐Adult Day Services:_____
d. ☐Housing Authority: _____
e. ☐Dept for Children and Families: _____
f. ☐Mental Health Agency:_____
g. ☐Other: _____
h. ☐Don't Know: _____

2. Check all home health services currently in place:
a. ☐Home Health Aide (LNA)
b. ☐Homemaker
c. ☐Hospice Services
d. ☐Nursing Services (RN)
e. ☐Social Work Services
f. ☐Therapy (check ☐PT, ☐OT, ☐ST)
g. ☐None of the above

3. Check all community-based services that are currently in place:

a. ☐Adult Day Services/Day Health Rehab
b. ☐Attendant Services Program (PDAC)
c. ☐Developmental Disability Services
d. ☐Children's Personal Care Services
e. ☐Medicaid High-Tech Services
f. ☐Traumatic Brain Injury Waiver
g. ☐Veterans Benefits/Services
h. ☐Mental Health Services (CRT)
i. ☐None of the above

SECTION G: Choice of Case Management Agency *(Home-based and ERC settings only)*

For Home-Based and ERC settings, you must choose one of the below agencies to provide case management services. The case manager will assist with the eligibility process, ongoing assessment and coordination of long-term care services.

☐Area Agency on Aging ***-OR-*** ☐Home Health Agency

SECTION H: Person/Agency Completing Form

Person Completing Form: _____

Agency Name: _____ Phone Number: _____
Address:_____

Signature: _____ Date:_____

SECTION I: Health & Functional Assessment

Check the most recent type of assessment available. **Include a copy with this referral**.

☐ILA (AAA, Adult Day) ☐OASIS (Home Health Agency) ☐ Other: _____
☐MDS (Nursing Home) ☐RCHRAT (Residential Care/ALR) ☐ None

Comments (optional):

By signing this referral form, the individual/legal representative agrees to the following statements:

- I wish to be referred to the Vermont Long-Term Care Medicaid program.
- I understand that I have the right to choose between long-term care settings.
- I understand that my name may be placed on a waiting list and I will be notified if this is the case.
- I agree to provide personal, medical and financial information to the persons who will determine my eligibility and provide services.
- I give permission for the referring agency (if applicable) to supply a copy of my recent health and functional assessment to the Department of Aging and Independent Living for the purpose of eligibility determination.
- I give permission for the Department of Aging and Independent Living staff to contact the facility I am currently at (if applicable), my legal representative and the agencies and medical providers I am currently involved with in order to determine eligibility and to eliminate duplication of effort.
- I understand that I must meet the general, clinical and financial eligibility criteria to be eligible for VT Long-Term Care Medicaid services.
- I understand that if I am found eligible, I may be required to pay a portion of the cost of Long-Term Care Medicaid services, as determined by the Department for Children and Families (DCF).

- I understand that if I am found eligible, my clinical and financial eligibility will be periodically reassessed.
- I understand that if I am found eligible and receive Long-Term Care Medicaid services, under certain circumstances the Office of VT Health Access (OVHA) Estate Recovery Unit may recover the cost of providing these services from my estate. More information about Estate Recovery is available from the DCF.
- I understand that if I receive Long-Term Care Medicaid services and am subsequently found financially ineligible, I will be required to pay for services provided.
- I understand that if found ineligible for Long-Term Care Medicaid services, I will be informed of my appeal rights.
- **To the best of my knowledge, the information on this form is correct.**

Applicant/Legal Representative_____ _____
Signature *Date*

Mail or FAX referral with attachments to:
Department of Aging and Independent Living
Medicaid Waiver Administration
Osgood I, 103 South Main Street
Waterbury, VT 05671-2301
FAX: 1-802-241-2325

Official Use Only
ACCESS Code:

VERMONT INDEPENDENT LIVING ASSESSMENT

COVER SHEET

Directions: *Complete pages 1-9 for all AAA services, Homemaker program, Medicaid Waiver, Adult Day, ASP, and HASS program.* ***Arrow → indicates that the question is to be answered by the individual only.*** *For all other questions, if the individual is unable to answer questions, obtain information from family/caregiver(s) or legal representative(s) as necessary with appropriate authorization to release information. Highlighted "Assessor Action" notes appear when action may be necessary.*

A. INDIVIDUAL IDENTIFICATION

1. Date of Assessment: _____ 2. Unique ID# _____

3. Name: _____
a. *(Last)* *b. (First)* *c. (M.I.)*

4. Also known as: _____
a. *(Last)* *b. (First)* *c. (M.I.)*

5. Phone: _____ 6. SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___

7. DOB: ____ - ____ - ____ 8. Age: ____ 9. Gender: ☐Male ☐Female
Month Day Year

10. Mailing Address:
a. Street/P.O. Box _____
Street_____

b. City/Town _____

c. State _____ d. Zip _____

11. Residence *(if different than mailing)*:
a.

b. City/Town _____

c. State _____

B. EMERGENCY CONTACT INFORMATION

1. Spouse/Partner: _____
a. (Name) *b. (Phone)*

2. Primary Physician: _____
a. (Name) *b. (Phone)*

3. Friend or relative (other than spouse/partner) to contact in case of an emergency:

_____/_____
a. *(Name)* *b. (Relationship)* *c. (Work Phone)* *d. (Home Phone)*

C. DIRECTIONS TO HOME

SECTION 1: Intake

A. ASSESSMENT INFORMATION

Date: _____ 1. ☐Initial Assess ☐Reassessment ☐Update

2. Individual's reason for requesting help:
_____

3. Where interviewed:
A. ☐Home B. ☐Hospital C. ☐Nursing Home D. ☐Adult Day E. ☐Other
_____

4. Did someone help the individual or answer questions for the individual? A. ☐Yes B. ☐ No

5. a. If "Yes", helper's name: _____ b. Helper's relationship:
_____

6. Primary language:
_____

7. Communication/Language assistance needed for assessment? A. ☐Yes B. ☐ No

8. If "Yes", type of assistance: _____

9. ILA completed by: _____ 10. Agency:
_____

11. ILA being completed for which DA&D program *(if applicable)*:
A. ☐ Adult Day B. ☐ASP C. ☐HASS D. ☐ Homemaker E. ☐ Medicaid Waiver F. ☐ NONE

B. LEGAL REPRESENTATIVE

Check all that apply:

a. Yes (✓)	b. Name	c. Phone (W	d. Phone (H)
1. ☐Power of Attorney			
2. ☐Representative Payee			
3. ☐Legal Guardian			
4. ☐*DPOA for Health Care			
5. ☐*Living Will/ *Copy held by:*			

6. *If no DPOA or Living Will, was information provided about advance directives? A. ☐Yes B. ☐ No

C. DEMOGRAPHICS

1. What is your marital status?
A. ☐ single C. ☐civil union E. ☐ separated
B. ☐ married D. ☐ widowed F. ☐ divorced G. ☐ information unavailable

2. What is your race or ethnic background?

A. ☐White
B. ☐African-American
C. ☐Asian or Pacific Island
D. ☐American Indian/Alaskan Native
E. ☐Hispanic
F. ☐info. unavailable
G. ☐Other:_____

3. Do you live in:

A. ☐house
B. ☐mobile home
C. ☐private apartment
D. ☐apartment in senior housing
E. ☐assisted living residence
F. ☐ residential care home
G. ☐ nursing home
H. ☐ information unavailable
I. ☐ other (describe)_____

4. Do you live:

A. ☐ alone
B. ☐with spouse/partner
C. ☐with spouse and child
D. ☐ with child or children (including adult child)
E. ☐with others _____

5. Are you currently employed? A. ☐ Yes B. ☐ No

6. How many related people reside together in your household (counting yourself)?

A. ☐ 1 person
B. ☐ 2 people
C. ☐ 3 people
D. ☐ 4 or more
E. ☐ info. unavailable

7. What is the estimated total monthly income for your household? (*Based on 2004 Federal Poverty Limits)*

A. ☐ $776 or less
B. ☐ $1041 or less
C. ☐$1306 or less
D. ☐$1571 or less
E. ☐$1572 or more
F. ☐ info. unavailable

D. HEALTH RELATED QUESTIONS

D1. General Questions

1. →How do you rate your health? Would you say that it is excellent, good, fair, or poor?

A. ☐***Excellent*** ***B.*** ☐***Good*** ***C.*** ☐***Fair*** ***D.*** ☐***Poor*** ***E.*** ☐***No response***

2. Were you admitted to a hospital for any reason in the last 30 days? A. ☐Yes B. ☐No

3. In the past year, how many times have you stayed overnight in a hospital?

A. ☐not at all B. ☐one time C. ☐2 or 3 times D. ☐more than 3 times

4. Have you ever stayed in a nursing home, residential care home or other institution (including Brandon Training School and Vermont State Hospital)? A. ☐Yes B. ☐No

5. Have you fallen in the last 3 months? A. ☐Yes B. ☐ No

6. Do you use a walker or four-prong cane (or equivalent), at least some of the time, to get around?

A. ☐Yes B. ☐No

7. Do you use a wheelchair, at least some of the time, to get around? A. ☐Yes B. ☐No

8. In the past month how many days a week have you usually gone out of the house/building where you live?

A. ☐Two or more days a week B. ☐One day a week or less

9. How many days a week are you physically active for at least 30 minutes? This includes any activity that causes small increases in breathing or heart rate that you do for at least 10 minutes at a time. (Such as walking, gardening, housework, dancing.) _____ days/week

10. Do you **currently** have any of the following medical conditions or problems?
Skip #10 if completing Section 5: Health Assessment

	A. Yes	B. No		A. Yes	B. No
a. heart condition			l. ankle/leg swelling		
b. arthritis			m. urinary problems		
c. diabetes			n. speech problems		
d. cancer			o. hearing problems		
e stroke			p. vision problems		
f. neurological condition			q. dementia		
g. breathing condition			r. depression		
h. digestive problems			s. mental health condition		
i. muscle or bone problems			t. anxiety		
j. chronic pain			u. OTHER:		
k. chronic weakness/fatigue					

11. How many prescription medications do you take? ☐

D2. Functional Needs *SKIP ADL/IADL checklist if completing Section 6: Functional Assessment*

ADL/IADL checklist	a. **Without** help?		b. If "**No**", do you **have** help?		c. If **"Yes",** do you have **enough** help?	
CAN YOU:	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
1. get around inside your home?						
2. bathe?						
3. dress?						
4. get in and out of bed/chair?						
5. use the toilet?						
6. eat?						
7. manage personal hygiene?						
8. manage your money?						
9. do your laundry?						
10. do your shopping?						
11. take medication(s)?						
12. prepare your own meals?						
13. manage household maintenance?						

14. do ordinary housework?						
15. take out the garbage?						
16. use transportation?						
17. use the telephone?						

ADL/IADL Comments:

18. Do you need any of the following new, repaired or additional devices or home modifications to help you to continue to stay in your home? *(Check all that apply)*

A.	☐ ***Eyeglasses***	***G.***	☐ ***Dentures***
B.	☐ ***Cane or walker***	***H.***	☐ ***Ramp***
C.	☐ ***Wheelchair***	***I.***	☐ ***Doorways widened***
D.	☐ ***Assistive feeding devices***	***J.***	☐ ***Kitchen/bathroom modifications***
E.	☐ ***Assistive dressing devices***	***K.***	☐ ***Other:_____***
F.	☐ ***Hearing aid***	***L.***	☐ ***NONE OF THE ABOVE***

D3. Emotional Health

Script for #1-5 (optional) **"Your emotional health is just as important as your physical health. We've just reviewed your current physical health conditions and now I'd like to review your current emotional health."**

1. →Do you feel you have enough contact with family? A. ☐Yes B. ☐ No C. ☐ No response
2. →Do you feel you have enough contact with friends? A. ☐Yes B. ☐ No C. ☐ No response

During this past month:

3. →*Have you **often** felt downhearted or blue? A. ☐Yes B. ☐No C. ☐ No response
4. →*Have you been anxious a lot or bothered by your nerves? A. ☐Yes B. ☐No C. ☐ No response
5. →*Have you felt hopeless or helpless at all? A. ☐Yes B. ☐No C. ☐ No response

****If "Yes" to questions #3, 4 or5, complete Section 4: Emotional/Behavioral/Cognitive Status, A. Emotional Well-Being, page 12.***

D4. Cognitive Orientation

Script for #1-4 (optional) ***"Now I'd like to ask a few questions to see how well you're keeping track of time (or of things). For example: "***

1. →Could you please tell me what year it is? A. ☐correct B. ☐incorrect C. ☐No response

2. →Could you please tell me what month it is? A. ☐correct B. ☐incorrect C. ☐ No response

3. →Could you please tell me what day of the week it is? A. ☐correct B. ☐incorrect C. ☐ No response

4. →When you make a decision about something, in general how do you do it?
   A. ☐Independently and alone
   B. ☐Independently after talking it over with family or friends
   C. ☐Usually follow advice of family/friends
   D. ☐I let other people make decisions for me.
   E. ☐*No response*

Assessor Action

- HEALTH: If significant medical issues are apparent, discuss and make appropriate referral/s to physician, home health agency, or other health professional(s).
- FUNCTIONAL NEEDS: If help needed with ADLs, IADLs, assistive devices or home modifications, discuss and make appropriate referrals for assistance.
- EMOTIONAL HEALTH: For emotional health issues, consider options for Area Agency on Aging Eldercare Clinician, Home Health social services, community mental health, or other counseling/mental health professional.
- COGNITION: If "incorrect" answer to cognitive orientation questions, consider referral/s to physician, mental health professional, memory clinic, etc.

E. *The NSI DETERMINE Your Nutritional Health Checklist

Directions: Read the statements below. Circle "Yes" or "No". Add up the "Yes" answers and check the nutrition score.

Nutrition Checklist	A. Yes	B. No
1. Have you made changes in lifelong eating habits because of health problems? (such as diabetes, high blood pressure, etc.)	☐2	☐0
2. Do you eat fewer than 2 complete meals a day?	☐3	☐0
3. Do you eat fewer than 5 servings (1/2 cup each) of fruit or vegetables every day?	☐1	☐0
4. Do you have fewer than 2 servings of dairy products (such as milk, yogurt, cheese) or tofu every day?	☐1	☐0
5. Do you have **any** of the following problems that make it difficult for you to eat? Biting___ Chewing___ Swallowing___	☐2	☐0
6. Are there times when you do not have enough money to buy the food you need?	☐4	☐0
7. Do you eat most meals alone?	☐1	☐0
8. Do you take 3 or more prescribed or over-the-counter medications each day? (including aspirin, laxatives, antacids, herbs, inhalers, etc.)	☐1	☐0
9. Have you lost or gained 10 pounds or more in the last 6 months without trying? Loss___ Gain___	☐2	☐0
10. Are there times when you are not physically able to do one or more of the following? Shop for food___ Cook___ Eat on your own___	☐2	☐0
11. Do you have 3 or more drinks of beer, wine or liquor almost every day?	☐2	☐0

12. *Total "Yes" Score……* ☐

What does your total "Yes" score mean? If it is:

0– 2 Good! Recheck your nutritional score in 6 months.

3– 5 You are at moderate nutritional risk. See what you can do to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center, health department and/or physician can help. Recheck your nutritional score in 3 months.

6+ You are at high nutritional risk. You may want to talk with your doctor, dietitian or other qualified health or social services professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

***Adapted from the *DETERMINE Your Nutritional Health* Checklist developed by the Nutrition Screening Initiative**

Additional Nutrition Questions:

13. About how tall are you without your shoes? A. _____ inches B. ☐ info. unavailable

14. About how much do you weigh without your shoes? A. _____ pounds B. ☐ info. unavailable

15. Do you drink at least six (6) glasses of water, milk, fruit juice or decaffeinated beverage (excluding alcohol) each day? (one glass=8oz) A. ☐Yes B. ☐No C. ☐ info. unavailable

16. Do you eat at least two (2) servings of protein rich foods each day? (meat, fish, poultry, nuts, or legumes)

A. ☐Yes B. ☐No C. ☐ info. unavailable

◇Assessor Action◇

If the individual is at "high nutritional risk" per the NSI checklist, or has other nutritional issues, discuss and recommend appropriate referrals to a registered dietician (AAA or Home Health), physician, or other qualified professional(s).

F. FINANCIAL RESOURCES

Directions: ***Complete only information necessary for program participation.***

1. Monthly Income:

	Source	1. Individual	2. Spouse
a.	Social Security	$	$
b.	SSI	$	$
c.	Retirement/Pension	$	$
d.	Interest	$	$
e.	VA Benefits	$	$
f.	Wages/Salaries/Earnings	$	$
g.	Other	$	$
	Total Income:	$	$

2. Monthly Expenses:

a.	Rent / Mortgage	$
b.	Property Tax	$
c.	Heat	$
d.	Utilities	$
e.	House Insurance	$
f.	Telephone	$
g.	Medical Expenses	$
h.	Other:	$
i.	Other:	$
	Total Expenses:	$

3. Savings/Assets:

TYPE	1. Bank/Institution	2. Account No.	3. Amount
a. Checking			$

b. Savings			$
c. CD			$
d. Burial Account			$
e. Life Insurance			$ (cash value)
f. Other			$
g. Other			$

4. Health Insurance: (check all that apply)

Yes	No			
		a. Medicare A	Effective date:	Medicare #
		b. Medicare B	Effective date:	Mo. Premium: $
		c. Medigap	Company:	Mo. Premium: $
		d. LTC Insurance	Company:	Mo. Premium$
		e. Other		

Comments:

G. SERVICE/PROGRAM CHECKLIST *Refer to ILA Manual pages 25-32 for service description.*

	a. Check all Services/Programs that apply.	b. Want to Apply (✓)
Home Health Services (HH)	A. ☐ Home Health Aide (LNA)	A. ☐
	B. ☐ Homemaker	B. ☐
	C. ☐ Hospice Services	C. ☐
	D. ☐ Nursing Services (RN)	D. ☐
	E. ☐ Social Work Services	E. ☐
	F. ☐ Therapy (check ☐PT, ☐OT, ☐ST)	F. ☐
Community-Based Care Programs	G. ☐ Adult Day Services/Day Health Rehab	G. ☐
	H. ☐ Attendant Services Program	H. ☐
	I. ☐ Developmental Disability Services	I. ☐
	J. ☐ Medicaid Waiver (HB/ERC)	J. ☐
	K. ☐ Medicaid High-Tech Services	K. ☐
	L. ☐ Traumatic Brain Injury Waiver	L. ☐
Nutrition	M. ☐ Commodity Supplemental Food Program	M. ☐
	N. ☐ Congregate Meals (Sr. Center)	N. ☐

	O.	☐ Emergency Food Shelf/Pantry	O. ☐
	P.	☐ Home Delivered Meals	P. ☐
	Q.	☐ Senior Farmer's Market Nutrition Program	Q. ☐
Social Service Programs (SSP)	R.	☐ Area Agency on Aging Case Management	R. ☐
	S.	☐ Community Action Program (CAP)	S. ☐
	T.	☐ Community Mental Health Services	T. ☐
	U.	☐ Dementia Respite Grant Program/NFCSP Grant	U. ☐
	V.	☐ Eldercare Clinician	V. ☐
	W.	☐ Job Counseling/Vocational Rehabilitation	W. ☐
	X.	☐ Office of Public Guardian	X. ☐
	Y.	☐ Senior Companion Program	Y. ☐
	Z.	☐ VCIL Peer Counseling	Z. ☐
	AA.	☐ VT Assoc. for the Blind and Visually Impaired	AA. ☐
	BB.	☐ VT Legal Aid Services	BB. ☐
Housing Programs (HP)	CC.	☐ Assistive Community Care Services (ACCS)	CC. ☐
	DD.	☐ Housing and Supportive Services (HASS)	DD. ☐
	EE.	☐ Section 8 Voucher (Housing Choice)	EE. ☐
	FF.	☐ Subsidized Housing	FF. ☐
PATH Benefit Programs (PATH)	GG.	☐ Aid to Needy Families with Children	GG. ☐
	HH.	☐ Essential Persons Program	HH. ☐
	II.	☐ Food Stamp Program	II. ☐
	JJ.	☐ Fuel Assistance Program	JJ. ☐
	KK.	☐ General Assistance Program	KK. ☐
	LL.	☐ Medicaid	LL. ☐
	MM.	☐ QMB/SLMB	MM. ☐
	NN.	☐ Telephone "Lifeline" Discount	NN. ☐
	OO.	☐ VHAP (VT Health Access Program)	OO. ☐
	PP.	☐ VHAP Pharmacy	PP. ☐
	QQ.	☐ V-Script	QQ. ☐
Other Services	RR.	☐ Emergency Response System	RR. ☐
	SS.	☐ Supplemental Security Income (SSI)	SS. ☐
	TT.	☐ Veterans Benefits	TT. ☐
	UU.	☐ Weatherization Program (CAP)	UU. ☐
	VV.	☐ NONE OF THE ABOVE	

H. "SELF NEGLECT", ABUSE, NEGLECT, AND EXPLOITATION SCREENING

Directions: *The following information may be obtained from the assessor's observation or reports from the individual, involved family, friends or providers (i.e. Home Health Agency, physician, etc.).*

1. Is the individual refusing services and putting him/herself or others at risk of harm?
   A. ☐ Yes B. ☐ No C. ☐ info. unavailable

2. Is the individual exhibiting dangerous behaviors and putting him/herself or others at risk of harm?
   A. ☐ Yes B. ☐ No C. ☐ info. unavailable

3. Is the individual making clear, informed decisions about his/her needs and appear to understand the consequences of these decisions?

A. ☐Yes B. ☐No C. ☐ info. unavailable

4. Is there evidence (observed or reported) of suspected **abuse, neglect, or exploitation** by another person?

A. ☐Yes B. ☐No C. ☐ info. unavailable

Comments:

◇*Assessor Action*◇

SELF NEGLECT: If the answer to #1 or #2 is "Yes" the individual may be considered "Self-Neglect". Refer individuals 60 and older to the local Area Agency on Aging if necessary (AAA) (1-800-642-5119).Refer individuals under 60 to Adult Protective Services at 1-800-564-1612.

If the answer to #1 or #2 is "Yes" and the answer to # 3 is "Yes", consider a "Negotiated Risk" contract between service providers and the individual.

Make other appropriate referrals regarding "dangerous" behaviors. (i.e. legal, psychiatric, medical, behavioral consult, etc.)

ABUSE / NEGLECT / EXPLOITATION: If the answer to #4 is "Yes", mandated reporters must file a report of abuse, neglect, or exploitation in accordance with Vermont's Adult Abuse Statue (Title 33) within 48 hours to Adult Protective Services at 1-800-564-1612.

SECTION 2: Supportive Assistance

Date:_____ *(Chose One):* ☐Initial Assessment ☐Reassessment ☐Update

Directions: *Complete this section for Medicaid Waiver, Adult Day, ASP. May also complete if SECTION 1: Intake indicates a need for more information. If the individual is unable to answer the following questions, obtain information from family/caregiver or legal representative.*

The following questions are specifically in regards to unpaid caregivers, such as family, friends, volunteers.

1. Who is the primary unpaid person who usually helps you? *(Check one only)*
   - A. ☐Spouse or significant other
   - B. ☐Daughter or son
   - C. ☐Other family member
   - D. ☐Friend, neighbor or community member
   - E. ☐NONE *(If "NONE, go to Section 3: Living Arrangements)*

2. How often do you receive help from this person? *(Check one only)* ***Skip if #3 is NONE.***
   - A. ☐Several times during day and night
   - B. ☐ Several times during day
   - C. ☐Once daily
   - D. ☐Three or more times per week
   - E. ☐One to two times per week
   - F. ☐Less often than weekly
   - G. ☐Unknown

3. What type of help does this person provide? *(Mark all that apply)* ***Skip if #3 is NONE.***
   - A. ☐ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)
   - B. ☐ IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances, transportation)
   - C. ☐Environmental support (housing, home maintenance)
   - D. ☐Psychosocial support (socialization, companionship, recreation)
   - E. ☐Advocates or facilitates individual's participation in appropriate medical care
   - F. ☐Financial agent, power of attorney, or conservator of finance
   - G. ☐Health care agent, conservator of person, or medical power of attorney
   - H. ☐Unknown

4. Record information on primary unpaid caregiver in #1: ***Skip if #1 is NONE.***

_____

a. (Name) *b. (Relationship)* *c. (Phone)*

_____

d. (Address)

Question #7 is to be asked of the primary caregiver identified in question #4a.

5. Which of the following areas are affected by your role as a caregiver?

A. ☐job D. ☐physical health
B. ☐finances E. ☐emotional health
C. ☐family responsibilities F. ☐ other:
_____

Comments:

⟐Assessor Action⟐

If the primary caregiver indicates factors in #5, discuss options for family support services and make appropriate referrals. For further caregiver assessment and planning, consider completing the "Caregiver Self-Assessment Questionnaire".

SECTION 3: Living Environment

Date: _____ ***(Chose One):*** ☐**Initial Assessment** ☐**Reassessment** ☐**Update**

Directions: ***Complete this section for Medicaid Waiver, Adult Day, ASP. May also complete if SECTION 1: Intake indicates a need for more information. If the individual is unable to answer the following questions, mark the following issues that are reported by the family/caregiver(s) observed by the assessor. Be as complete as possible.***

1. Do any of the following issues make it difficult for you to get around your home? ***(Mark all that apply)***

A. ☐Stairs inside home which must be used by the individual (e.g., to get to toileting, sleeping, eating areas)
B. ☐Stairs inside home which are used optionally (e.g., to get to laundry facilities)
C. ☐Stairs leading from inside house to outside
D. ☐Narrow or obstructed doorways
E. ☐Other (specify)_____
F. ☐NONE OF THE ABOVE

2. Do any of the following safety issues exist in your home? *(Mark all that apply)*

A. ☐Inadequate floor, roof, or windows
B. ☐Inadequate lighting
C. ☐Unsafe gas/electric appliance
D. ☐Inadequate heating
E. ☐Inadequate cooling
F. ☐Absence of working smoke detectors
G. ☐Unsafe floor coverings
H. ☐Inadequate stair railings
I. ☐Improperly stored hazardous materials
J. ☐Lead-based paint
K. ☐Other (specify)_____
L. ☐NONE OF THE ABOVE

3. Do any of the other following sanitation issues exist in your home? *(Mark all that apply)*

A. ☐No running water
B. ☐Contaminated water

C. ☐No toileting facilities
D. ☐Outdoor toileting facilities only
E. ☐Inadequate sewage disposal
F. ☐Inadequate/improper food storage
G. ☐No food refrigeration
H. ☐No cooking facilities
I. ☐Insects/rodents present
J. ☐No scheduled trash pickup
K. ☐Cluttered/soiled living area
L. ☐Other (specify)_____
M. ☐NONE OF THE ABOVE

Comments:

⟐Assessor Action⟐

If the individual's living arrangements indicate significant safety or health issues, discuss and make appropriate referral(s) for home repair, cleaning, and/or pest extermination.

SECTION 4: Emotional/Behavioral/Cognitive Status

Date:_____ ***(Chose One):*** ☐Initial Assessment ☐Reassessment ☐ Update

Directions: *Complete this section for Medicaid Waiver, Adult Day, ASP. May also complete if SECTION 1: Intake indicates a need for more information.*

A. EMOTIONAL WELL-BEING

Complete questions #1- 11 only if the individual answered "Yes" to D3. Emotional Health questions #3, 4, or 5, Section 1: Intake.

"I'd like you to think about your moods and feelings in the last month."

1. Have you felt satisfied with your life? A. ☐Yes B. ☐No C. ☐Sometimes D. ☐No response
2. Have you had a change in your sleeping patterns? A. ☐Yes B. ☐No C. ☐Sometimes D. ☐No response
3. Have you had a change in your appetite? A. ☐Yes B. ☐No C. ☐Sometimes D. ☐No response
4. *Have you often felt depressed, sad or very unhappy? A. ☐Yes B. ☐No C. ☐Sometimes D. ☐No response

***If answer is YES or SOMETIMES to #4, ask the next question. If answer is NO, go to #10.**

5. *Have you thought about harming yourself? A. ☐Yes B. ☐No

***If answer is YES to #5, ask the next questions. If answer is NO, go to #10.**

6. **Do you have a plan? A. ☐Yes B. ☐No
7. **Do you have the means to carry out your plan? A. ☐Yes B. ☐No
8. **Do you intend to carry this out? A. ☐Yes B. ☐No
9. **Have you harmed yourself before? A. ☐Yes B. ☐No

10. Are you currently receiving psychiatric and/or counseling services?
A. ☐ No B. ☐Yes C. ☐info. unavailable

11. If "Yes", are you receiving services: A. ☐At home B. ☐In the community
C. ☐both

B. BEHAVIORAL STATUS

Directions: *For each question, check one answer for each behavior in last 7 days. Information may be gathered from family, caregiver(s) or assessor's observations.*

1.a. How often does the individual get lost or wander? (Moves with no rational purpose, seemingly oblivious to needs or safety.) ☐0 – Never ☐1 – Less than daily ☐2 – Daily

1.b. In the last 7 days, was the wandering alterable?
☐0 – Behavior was not present **-OR-** was easily altered ☐1 – Behavior was NOT easily altered

2.a. How often is the individual verbally abusive to others? (Others were threatened, screamed at, cursed at.)
☐0 – Never ☐1 – Less than daily ☐2 – Daily

2.b. In the last 7 days, was the verbal abuse alterable?
☐0 – Behavior was not present **-OR-** was easily altered ☐1 – Behavior was NOT easily altered

3.a. How often is the individual physically abusive to others? (Others were hit, shoved, scratched, sexually abused.)
☐0 – Never ☐1 – Less than daily ☐2 – Daily

3.b. In the last 7 days, was the physical abuse alterable?
☐0 – Behavior was not present **-OR-** was easily altered ☐1 – Behavior was NOT easily altered

4.a. How often does the individual exhibit socially inappropriate/disruptive behavior? (Makes disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings.)
☐0 – Never ☐1 – Less than daily ☐2 – Daily

4.b. In the last 7 days, was the socially disruptive behavior alterable?
☐0 – Behavior was not present **-OR-** was easily altered ☐1 – Behavior was NOT easily altered

5.a. How often did the individual display symptoms of resisting care? (Resists taking medications/injections, ADL assistance, or eating.)
☐0 – Never ☐1 – Less than daily ☐2 – Daily

5.b. In the last 7 days, was the resisting care behavior alterable?
☐0 – Behavior was not present **-OR-** was easily altered ☐1 – Behavior was NOT easily altered

C. COGNITIVE STATUS

Directions: *Information may be gathered from family/caregiver(s) or assessor's observations. Check the one answer for each that best describes the individual's cognitive status.*

1. Memory and use of information:
   E. ☐Does not have difficulty remembering and using information. Does not require directions or reminding from others.
   F. ☐Has minimal difficulty remembering and using information. Requires direction and reminding from others 1 to 3 times per day. Can follow simple written instructions.
   G. ☐Has difficulty remembering and using information. Requires direction and reminding from others 4 or more times per day.
   H. ☐Cannot remember or use information. Requires continual verbal reminding.

2. Global confusion:
   A. ☐Appropriately responsive to environment.
   B. ☐Nocturnal confusion on awakening.
   C. ☐Periodic confusion during daytime.
   D. ☐Nearly always confused.

3. Verbal communication:
   A. ☐Speaks normally.
   B. ☐Minor difficulty with speech or word-finding difficulties.
   C. ☐Able to carry out only simple conversations.
   D. ☐Unable to speak coherently or make needs known.

4. Cognitive Skills for Daily Decision-Making
   E. ☐Independent – decisions consistent/reasonable
   F. ☐Modified independence – some difficulty in new situations only
   G. ☐Moderately impaired – decision poor/cues/supervision required
   H. ☐Severely impaired – never/rarely makes decisions

◈Assessor Action◈

*****If "YES" to Emotional Well-Being questions #6-8, contact the appropriate local crisis authorities immediately. Discuss other psychiatric and/or mental health counseling services and make appropriate referrals. Make appropriate referrals regarding behavioral/cognitive symptoms as necessary.***

SECTION 5: Health Assessment

Date:_____ ***(Chose One):*** ☐Initial Assessment ☐Reassessment ☐ Update

Directions*: Complete this section for Medicaid Waiver, Adult Day, ASP. May also complete if SECTION 1: Intake indicates a need for more information. If the individual is unable to answer the following questions, obtain information from family/caregiver(s), legal representative and/or medical records.*

A. DIAGNOSIS/CONDITIONS/TREATMENTS

1. **Diagnosis:** List the primary medical diagnosis for which the individual is receiving

services/treatments.

Primary Diagnosis: _____

2. **Other Disease Diagnosis:** *Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses.)*

Endocrine/Metabolic/Nutritional		X.	☐ Paraplegia
A.	☐ Diabetes mellitus	Y.	☐ Parkinson's disease
B.	☐ Hyperthyroidism	Z.	☐ Quadriplegia
C.	☐ Hypothyroidism	AA.	☐ Seizure disorder
Heart/Circulation		BB.	☐ Transient ischemic attack (TIA)
D.	☐ Arteriosclerotic heart disease	CC.	☐ Traumatic brain injury
E.	☐ Cardiac dysrhythmias	**Psychiatric/Mood**	
F.	☐ Congestive heart failure	DD.	☐ Anxiety disorder
G.	☐ Deep vein thrombosis	EE.	☐ Depression
H.	☐ Hypertension	FF.	☐ Manic depressive/bipolar disease
I.	☐ Hypotension	GG.	☐ Schizophrenia
J.	☐ Peripheral vascular disease	**Pulmonary**	
K.	☐ Other cardiovascular disease	HH.	☐ Asthma
Musculoskeletal		II.	☐ Emphysema/COPD
L.	☐ Arthritis	**Sensory**	
M.	☐ Hip fracture	JJ.	☐ Cataracts
N.	☐ Missing limb	KK.	☐ Diabetic retinopathy
O.	☐ Osteoporosis	LL.	☐ Glaucoma
P.	☐ Pathological bone fracture	MM.	☐ Macular degeneration
Neurological		**Other**	
Q.	☐ Alzheimer's disease	NN.	☐ Allergies
R.	☐ Aphasia	OO.	☐ Anemia
S.	☐ Cerebral palsy	PP.	☐ Cancer
T.	☐ Cerebrovascular accident (stroke)	QQ.	☐ Renal failure
U.	☐ Dementia other than Alzheimer's disease	RR.	☐ NONE OF THE ABOVE
V.	☐ Hemiplegia/hemiparesis	SS.	☐ OTHER:
W.	☐ Multiple sclerosis	TT.	☐ OTHER:

3. **Infections:** *Check all that apply. If none apply, check the NONE OF THE ABOVE box.*

A.	☐ Antibiotic resistant infection	H.	☐ Sexually transmitted disease
B.	☐ Clostridium difficile	I.	☐ Tuberculosis
		J.	☐ Urinary tract infection *in last 30 days*
C.	☐ Conjunctivitis		
D.	☐ HIV infection	K.	☐ Viral hepatitis
E.	☐ **Pneumonia**	L.	☐ Wound infection
F.	☐ Respiratory infection	M.	☐ OTHER:
G.	☐ Septicemia	N.	☐ NONE OF THE ABOVE

4. **Problem Conditions:** *Check all problems present in the last 7 days.*

A.	☐ Dehydration	I.	☐ Syncope (fainting)

B. ☐Delusions
C. ☐Dizziness/Vertigo
D. ☐Edema
E. ☐Fever
F. ☐Internal bleeding
G. ☐Recurrent lung aspirations ***in last 90 days***
H. ☐Shortness of breath
J. ☐Unsteady gait
K. ☐Vomiting (recurring)
L. ☐End stage disease, 6 or fewer months to live
M. ☐NONE OF THE ABOVE
N. ☐OTHER:

5. **Special Care/Treatments:** *Check all treatments received during the last 14 days.*

A. ☐Chemotherapy
B. ☐Dialysis
C. ☐IV meds
D. ☐Intake/output
E. ☐Monitoring acute medical condition
F. ☐Ostomy care
G. ☐Oxygen therapy
H. ☐Radiation
I. ☐Suctioning
J. ☐Tracheostomy Care
K. ☐Transfusions (specify)
L. ☐Ventilator or respirator
M. ☐NONE OF THE ABOVE
N. ☐OTHER:

6. **Therapies:** *Check all therapies received in last 7 days.*

A. ☐Speech Therapy
B. ☐Occupational Therapy
C. ☐Physical Therapy
D. ☐Respiratory Therapy
E. ☐NONE OF THE ABOVE

7. Does the individual currently receive at least 45 minutes/day for at least 3 days week of PT or a combination of PT, ST, or OT? A. ☐Yes B. ☐No C. ☐info. unavailable

8. Check all nutritional issues in the last 7 days. *(Mark all that apply)*

A. ☐Parenteral/IV
B. ☐Feeding tube
C. ☐Mechanically altered diet
D. ☐Syringe (oral feeding)
E. ☐Therapeutic diet
F. ☐Dietary supplement between meals
G. ☐Plate guard, stabilized built-up utensil, etc.
H. ☐On a planned weight change program
I. ☐Oral liquid diet
J. ☐NONE OF THE ABOVE

9. Check all current high risk factors characterizing this individual. *(Mark all that apply)*

A. ☐Smoking
B. ☐Obesity
C. ☐Alcohol dependency
D. ☐Drug dependency
E. ☐ Unknown
F. ☐ Other:_____

G. ☐ NONE OF THE ABOVE

B. PAIN STATUS

1. What is the frequency of pain interfering with individual's activity or movement? C*heck one.*

A. ☐Individual has **no** pain or pain does **not** interfere with activity or movement
B. ☐Less often than daily
C. ☐Daily, but not constantly
D. ☐All of the time
E. ☐Info. unavailable

2. Is the individual experiencing pain that is not easily relieved, occurs at least daily, and affects the individual's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?

A. ☐Yes B. ☐No C. ☐info. unavailable

C. SKIN STATUS

1.a. Specify the highest stage (1-4) for any pressure ulcer(s) the individual currently has. Specify 0 if no pressure ulcer(s).

Stage: _____

1.b. Specify the highest stage (1-4) for any stasis ulcer(s) the individual currently has. Specify 0 if no pressure ulcer(s).

Stage: _____

Key for Ulcer Stages

Stage 1: A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
Stage 2: A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
Stage 3: A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.
Stage 4: A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

2. Indicate which of the following skin problems the individual has that requires treatment. *Check all that apply during last 7 days.*

E. ☐Abrasions, bruises
F. ☐Burns (second or third)
G. ☐Open lesions other than ulcers, rashes, cuts (e.g. cancer lesions)
H. ☐Rashes (e.g. intertrigo, eczema, drug rash, heat rash, herpes zoster)
I. ☐Skin desensitized to pain or pressure
J. ☐Skin tears or cuts (other than surgery)
K. ☐Surgical wounds
L. ☐NONE OF THE ABOVE

D. ELIMINATION STATUS

1. Has the individual been treated for a urinary tract infection (UTI) in the last 14 days? A. ☐ Yes B. ☐ No

2. Does the individual have urinary incontinence?
   D. ☐ Yes
   E. ☐ No incontinence and no urinary catheter
   F. ☐ No incontinence, individual has urinary catheter
   If answer is b. or c., go to question #5.

3. What is the frequency of urinary incontinence?

   A. ☐ less than once weekly
   B. ☐ one to three times weekly
   C. ☐ four to six times weekly
   D. ☐ one to three times daily
   E. ☐ four or more times daily

4. When does urinary incontinence occur?

   A. ☐ during the day only B. ☐ during the night only C. ☐ during the day and night

5. Does the individual have bowel incontinence?
   A. ☐ Yes
   B. ☐ No incontinence and no ostomy
   C. ☐ No incontinence, individual has an ostomy
   If answer is b. or c., go to question #8.

6. What is the frequency of bowel incontinence?

   A. ☐ less than once weekly
   B. ☐ one to three times weekly
   C. ☐ four to six times weekly
   D. ☐ one to three times daily
   E. ☐ four or more times daily

7. When does bowel incontinence occur?

   A. ☐ during the day only B. ☐ during the night only C. ☐ during the day and night

8. Has the individual experienced recurring bouts of diarrhea in the last 7 days?

A. ☐ Yes B. ☐ No

9. Has the individual experienced recurring bouts of constipation in the last 7 days?

A. ☐ Yes B. ☐ No

Comments:

Name of RN (*print*): _____

Agency: _____

Signature of RN:_____Date:_____

Adult Day Only/ LPN completing health assessment:_____

Assessor Action

Incorporate Health Assessment issues into the appropriate plan for services. Make appropriate referrals for identified unmet health needs.

SECTION 6: Functional Assessment

Date:_____ ☐Initial Assessment ☐Reassessment ☐Update

Directions*: Complete for Medicaid Waiver, ASP and Adult Day. If the individual is unable to answer the following questions, obtain information from family/caregiver(s), service provider(s), and/or assessor's observations.*

A. ACTIVITIES OF DAILY LIVING (ADL's)

1.a. **DRESSING:** During the last 7 days, how would you rate the individual's ability to dress? (Putting on, fastening, and taking off all items of clothing, including donning/removing prosthesis.)

☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

1.b. Select the item for the most support provided for dressing during the last 7 days.

☐0 - No setup or physical help
☐1 - Setup help only
☐2 - One person physical assist
☐3 - Two+ persons physical assist
☐8 - Activity did not occur during entire 7 days –**OR-** Unknown

1.c. What was the individual's level of unmet need for dressing during the last 7 days?

☐A – Need was seldom or never met
☐B – Need was met, no need for additional help
☐C – Unknown

1.d. Dressing Comments:

2.a. **BATHING:** During the last 7 days, how would you rate the individual's ability to perform bathing? (Taking a full-body bath/shower, sponge bath, including transferring in/out of tub/shower.)

☐0 - **Independent:** No help provided
☐1 - **Supervision:** Oversight/cueing only
☐2 - **Limited Assist:** Physical help limited to transfer only
☐3 - **Extensive Assist:** Physical help in part of bathing activity
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

2.b. Select the item for the most support provided for bathing during the last 7 days.

☐0 - No setup or physical help
☐1 - Setup help only
☐2 - One person physical assist

☐3 - Two+ persons physical assist
☐8 - Activity did not occur during entire 7 days –**OR-** Unknown

2.c. What was the individual's level of unmet need for bathing during the last 7 days?
☐A – Need was seldom or never met
☐B – Need was met, no need for additional help
☐C – Unknown

2.d. Bathing Comments:

3.a. **PERSONAL HYGIENE:** During the last 7 days, how would you rate the individual's ability to perform personal hygiene? (Combing hair, brushing teeth, shaving, washing/drying face, hands, and perineum, EXCLUDE baths and showers.)
☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

3.b. Select the item for the most support provided for personal hygiene during the last 7 days.
☐0 - No setup or physical help
☐1 - Setup help only
☐2 - One person physical assist
☐3 - Two+ persons physical assist
☐8 - Activity did not occur during entire 7 days –**OR-** Unknown

3.c. What was the individual's level of unmet need for personal hygiene during the last 7 days?
☐A – Need was seldom or never met
☐B – Need was met, no need for additional help
☐C – Unknown

3.d. Personal Hygiene Comments:

4.a. **BED MOBILITY:** During the last 7 days, how would you rate the individual's ability to perform bed mobility? (Moving to and from lying position, turning side-to-side, and positioning body while in bed.)

☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

4.b. Select the item for the most support provided for bed mobility during the last 7 days.
☐0 - No setup or physical help
☐1 - Setup help only
☐2 - One person physical assist
☐3 - Two+ persons physical assist
☐8 - Activity did not occur during entire 7 days –**OR-** Unknown

4.c. What was the individual's level of unmet need for bed mobility during the last 7 days?
☐A – Need was seldom or never met
☐B – Need was met, no need for additional help
☐C – Unknown

4.d. Bed Mobility Comments:

5.a. **TOILET USE:** During the last 7 days, how would you rate the individual's ability to perform toilet use? (Using the toilet, commode, bedpan, urinal; transferring on/off toilet, cleansing self, managing incontinence pad(s), managing ostomy or catheter, adjusting clothes.)
☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

5.b. Select the item for the most support provided for toilet use during the last 7 days.
☐0 - No setup or physical help
☐1 - Setup help only
☐2 - One person physical assist
☐3 - Two+ persons physical assist
☐8 - Activity did not occur during entire 7 days –**OR-** Unknown

5.c. What was the individual's level of unmet need for toilet use during the last 7 days?

☐A – Need was seldom or never met
☐B – Need was met, no need for additional help
☐C – Unknown

5.d. Toilet Use Comments:

6.a. **ADAPTIVE DEVICES:** During the last 7 days, how would you rate the individual's ability to manage putting on and removing braces, splints, and other adaptive devices?

☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

6.b. Select the item for the most support provided for adaptive devices use during the last 7 days.

☐0 - No setup or physical help
☐1 - Setup help only
☐2 - One person physical assist
☐3 - Two+ persons physical assist
☐8 - Activity did not occur during entire 7 days –**OR-** Unknown

6.c. What was the individual's level of unmet need for help with adaptive devices during the last 7 days?

☐A – Need was seldom or never met
☐B – Need was met, no need for additional help
☐C – Unknown

6.d. Adaptive Devices Comments

7.a. **TRANSFERRING:** During the last 7 days, how would you rate the individual's ability to perform transferring? (Moving between surfaces – to/from bed, chair, wheelchair, standing position , EXCLUDES to/from bath/toilet.)

☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times

☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days

☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

7.b. Select the item for the most support provided for transferring during the last 7 days.

☐0 - No setup or physical help
☐1 - Setup help only
☐2 - One person physical assist
☐3 - Two+ persons physical assist
☐8 - Activity did not occur during entire 7 days –**OR-** Unknown

7.c. What was the individual's level of unmet need for transferring during the last 7 days?

☐A – Need was seldom or never met
☐B – Need was met, no need for additional help
☐C – Unknown

7.d. Transferring Comments:

8.a. **MOBILITY:** During the last 7 days, how would you rate the individual's ability to perform mobility in the home? (Moving between locations in his/her home. If in wheelchair, self-sufficiency once in wheelchair.)

☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times

☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times

☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times

☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times

☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days

☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

8.b. Select the item for the most support provided for mobility during the last 7 days.

☐0 - No setup or physical help
☐1 - Setup help only
☐2 - One person physical assist
☐3 - Two+ persons physical assist
☐8 - Activity did not occur during entire 7 days –**OR-** Unknown

8.c. What was the individual's level of unmet need for mobility during the last 7 days?

☐A – Need was seldom or never met
☐B – Need was met, no need for additional help
☐C – Unknown

8.d. Mobility Comments:

9.a. **EATING:** During the last 7 days, how would you rate the individual's ability to perform eating? (Ability to eat and drink (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition).)

- ☐0 - **Independent:** No help at all**—OR—**help/oversight provided only 1 or 2 times
- ☐1 - **Supervision:** Oversight/cueing 3 + times**—OR—** oversight/cueing plus physical help 1 or 2 times
- ☐2 - **Limited Assist:** Non-wt. bearing physical help 3 + times**—OR—**non-wt. bearing physical help plus extensive help 1 or 2 times
- ☐3 - **Extensive Assist:** Wt.-bearing help or full caregiver assistance 3 + times
- ☐4 - **Total Dependence:** Full caregiver assistance each time the activity occurred during last 7 days
- ☐8 - Activity did not occur (as defined) in last 7 days **–OR-** Unknown

9.b. Select the item for the most support provided for eating during the last 7 days.

- ☐0 - No setup or physical help
- ☐1 - Setup help only
- ☐2 - One person physical assist
- ☐3 - Two+ persons physical assist
- ☐8 - Activity did not occur during entire 7 days –**OR-** Unknown

9.c. What was the individual's level of unmet need for eating during the last 7 days?

- ☐A – Need was seldom or never met
- ☐B – Need was met, no need for additional help
- ☐C – Unknown

9.d. Eating Comments:

B. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL's)

1.a. **PHONE USE:** During the last 7 days, how would you rate the individual's ability to perform phone use? (Answering the phone, dialing numbers, and effectively using the telephone to communicate.)

- ☐0 - **Independent:** No help provided (With/without assistive devices)
- ☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐2 – **Done by Others**: Full caregiver assistance.
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

1.b. Select the item for the most support provided for phone use during the last 7 days.

- ☐0 – No support provided
- ☐1 – Supervision/Cueing only
- ☐2 – Setup only
- ☐3 – Physical assistance provided
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

1.c. What was the individual's level of unmet need for phone use during the last 7 days?

- ☐A – Need was seldom or never met
- ☐B – Need was met, no need for additional help
- ☐C – Unknown

1.d. Phone Use Comments:

2. a. **MEAL PREPARATION:** During the last 7 days, how would you rate the individual's ability to perform meal preparation? (Planning and preparing light meals or reheating delivered meals.)

- ☐0 - **Independent:** No help provided (With/without assistive devices)
- ☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐2 – **Done by Others**: Full caregiver assistance.
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

2.b. Select the item for the most support provided for meal prep during the last 7 days.

- ☐0 – No support provided
- ☐1 – Supervision/Cueing only
- ☐2 – Setup only
- ☐3 – Physical assistance provided
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

2.c. What was the individual's level of unmet need for meal prep during the last 7 days?

- ☐A – Need was seldom or never met
- ☐B – Need was met, no need for additional help
- ☐C – Unknown

2.d. Meal Prep Comments:

3.a **MEDICATIONS:** During the last 7 days, how would you rate the individual's ability to manage medications? (Preparing and taking all prescribed and over the counter medications reliably and safely, including the correct dosage at appropriate times/intervals.)

- ☐0 - **Independent:** No help provided (With/without assistive devices)
- ☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐2 – **Done by Others**: Full caregiver assistance.
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

3.b. Select the item for the most support provided for medication management during the last 7 days.

- ☐0 – No support provided
- ☐1 – Supervision/Cueing only
- ☐2 – Setup only
- ☐3 – Physical assistance provided
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

3.c. What was the individual's level of unmet need for medication management during the last 7 days?

- ☐A – Need was seldom or never met
- ☐B – Need was met, no need for additional help
- ☐C – Unknown

3.d. Medication Management Comments:

4.a. **MONEY MANAGEMENT:** During the last 7 days, how would you rate the individual's ability to perform money management? (Payment of bills, managing checkbook/account(s), being aware of potential exploitation, budgets, plans for emergencies, etc.)

- ☐0 - **Independent:** No help provided (With/without assistive devices)
- ☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐2 – **Done by Others**: Full caregiver assistance.
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

4.b. Select the item for the most support provided for money management during the last 7 days.

- ☐0 – No support provided
- ☐1 – Supervision/Cueing only
- ☐2 – Setup only
- ☐3 – Physical assistance provided
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

4.c. What was the individual's level of unmet need for money management during the last 7 days?

- ☐A – Need was seldom or never met
- ☐B – Need was met, no need for additional help
- ☐C – Unknown

4.d. Money Management Comments:

5.a. **HOUSEHOLD MAINTENANCE:** During the last 7 days, how would you rate the individual's ability to perform household maintenance? (Chores such as washing windows, shoveling snow, taking out the garbage and scrubbing floors.)

- ☐0 - **Independent:** No help provided (With/without assistive devices)
- ☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐2 – **Done by Others**: Full caregiver assistance.
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

5.b. Select the item for the most support provided for household maintenance during the last 7 days.

- ☐0 – No support provided
- ☐1 – Supervision/Cueing only
- ☐2 – Setup only
- ☐3 – Physical assistance provided
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

5.c. What was the individual's level of unmet need for household maintenance during the last 7 days?

- ☐A – Need was seldom or never met
- ☐B – Need was met, no need for additional help
- ☐C – Unknown

5.d. Household Maintenance Comments:

6.a. **HOUSEKEEPING:** During the last 7 days, how would you rate the individual's ability to perform housekeeping? (Housekeeping tasks such as dusting, sweeping, vacuuming, dishes, light mop, and picking up.)

- ☐0 - **Independent:** No help provided (With/without assistive devices)
- ☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐2 – **Done by Others**: Full caregiver assistance.
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

6.b. Select the item for the most support provided for housekeeping during the last 7 days.

- ☐0 – No support provided
- ☐1 – Supervision/Cueing only
- ☐2 – Setup only
- ☐3 – Physical assistance provided
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

6.c. What was the individual's level of unmet need for housekeeping during the last 7 days?

- ☐A – Need was seldom or never met
- ☐B – Need was met, no need for additional help
- ☐C – Unknown

6.d. Housekeeping Comments:

7.a. **LAUNDRY:** During the last 7 days, how would you rate the individual's ability to perform laundry? (Carrying laundry to and from the washing machine, using washer and dryer, washing small items by hand.)

- ☐0 - **Independent:** No help provided (With/without assistive devices)
- ☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐2 – **Done by Others:** Full caregiver assistance.
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

7.b. Select the item for the most support provided for laundry during the last 7 days.

- ☐0 – No support provided
- ☐1 – Supervision/Cueing only
- ☐2 – Setup only
- ☐3 – Physical assistance provided
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

7.c. What was the individual's level of unmet need for laundry during the last 7 days?

- ☐A – Need was seldom or never met
- ☐B – Need was met, no need for additional help
- ☐C – Unknown

7.d. Laundry Comments:

8.a. **SHOPPING:** During the last 7 days, how would you rate the individual's ability to perform shopping? (Planning, selecting, and purchasing items in a store and carrying them home or arranging delivery if available.)

- ☐0 - **Independent:** No help provided (With/without assistive devices)
- ☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐2 – **Done by Others:** Full caregiver assistance.
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

8.b. Select the item for the most support provided for shopping during the last 7 days.

- ☐0 – No support provided
- ☐1 – Supervision/Cueing only
- ☐2 – Setup only
- ☐3 – Physical assistance provided
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

8.c. What was the individual's level of unmet need for shopping during the last 7 days?

- ☐A – Need was seldom or never met
- ☐B – Need was met, no need for additional help
- ☐C – Unknown

8.d. Shopping Comments:

9.a **TRANSPORTATION:** During the last 7 days, how would you rate the individual's ability to perform transportation? (Safely using a car, taxi, or public transportation.)

- ☐0 - **Independent:** No help provided (With/without assistive devices)
- ☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐2 – **Done by Others:** Full caregiver assistance.
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

9.b. Select the item for the most support provided for transportation during the last 7 days.

- ☐0 – No support provided
- ☐1 – Supervision/Cueing only
- ☐2 – Setup only
- ☐3 – Physical assistance provided
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

9.c. What was the individual's level of unmet need for transportation during the last 7 days?

- ☐A – Need was seldom or never met
- ☐B – Need was met, no need for additional help
- ☐C – Unknown

9.d. Transportation Comments:

10.a. **CARE OF EQUIPMENT:** During the last 7 days, how would you rate the individual's ability to perform care of equipment? (Cleaning, adjusting or general care of adaptive/medical equipment such as wheelchairs, walkers, nebulizer, IV equipment etc.)

- ☐0 - **Independent:** No help provided (With/without assistive devices)
- ☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐2 – **Done by Others:** Full caregiver assistance.
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

10.b. Select the item for the most support provided for care of equipment during the last 7 days.

- ☐0 – No support provided
- ☐1 – Supervision/Cueing only
- ☐2 – Setup only
- ☐3 – Physical assistance provided
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

10.c. What was the individual's level of unmet need for care of equipment during the last 7 days?

- ☐A – Need was seldom or never met
- ☐B – Need was met, no need for additional help
- ☐C – Unknown

10.d. Care of Equipment Comments:

11.a. **CHILD CARE *(ASP Only)*:** During the last 7 days, how would you rate the individual's ability to perform child care? (Bathing, dressing and feeding of own child/children (to the extent that the dependent child cannot perform the tasks for him/herself).

- ☐0 - **Independent:** No help provided (With/without assistive devices)
- ☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐2 – **Done by Others:** Full caregiver assistance.
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

11.b. Select the item for the most support provided for child care during the last 7 days.

- ☐0 – No support provided
- ☐1 – Supervision/Cueing only
- ☐2 – Setup only
- ☐3 – Physical assistance provided
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

11.c. What was the individual's level of unmet need for child care during the last 7 days?

- ☐A – Need was seldom or never met
- ☐B – Need was met, no need for additional help
- ☐C – Unknown

11.d. Child Care Comments:

12.a. **SUPPORT ANIMALS *(ASP Only)*:** During the last 7 days, how would you rate the individual's ability to perform care of support animal(s). (Feeding, grooming and a minimum of walking of seeing-eye dogs, hearing-ear dogs, or other support animals.)

- ☐0 - **Independent:** No help provided (With/without assistive devices)
- ☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐2 – **Done by Others:** Full caregiver assistance.
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

12.b. Select the item for the most support provided for support animal(s) during the last 7 days.

- ☐0 – No support provided
- ☐1 – Supervision/Cueing only
- ☐2 – Setup only
- ☐3 – Physical assistance provided
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

12.c. What was the individual's level of unmet need for care of support animal(s) during the last 7 days?

- ☐A – Need was seldom or never met
- ☐B – Need was met, no need for additional help
- ☐C – Unknown

12.d. Support Animal(s) Comments:

13.a. **MOBILITY GUIDE *(ASP Only)*:** For individuals who are blind or visually impaired, during the last 7 days, how would you rate the individual's ability to get from place to place in and around the home, shopping, and in medical or educational facilities.

- ☐0 - **Independent:** No help provided (With/without assistive devices)
- ☐1 – **Done with Help:** Cueing, supervision, reminders, and/or physical help provided.
- ☐2 – **Done by Others:** Full caregiver assistance.
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

13.b. Select the item for the most support provided for mobility guide during the last 7 days.

- ☐0 – No support provided
- ☐1 – Supervision/Cueing only
- ☐2 – Setup only
- ☐3 – Physical assistance provided
- ☐8 – Activity did not occur (as defined) in last 7 days **–OR-** Unknown

13.c. What was the individual's level of unmet need for mobility guide during the last 7 days?

- ☐A – Need was seldom or never met
- ☐B – Need was met, no need for additional help
- ☐C – Unknown

13.d. Mobility Guide Comments:

Additional ADL/IADL Comments:

Assessor Action

If an “unmet need” has been identified, arrange for appropriate services and review functional assessment and services as needed.

Attachment E – Referral Procedures

A. Application Process

1. Department of Disabilities, Aging and Independent Living (DAIL) staff shall make Choices for Care Program Applications and information available to local agencies and organizations.

2. Hospitals and nursing facilities staff shall provide information packets to individuals at the time of admission or as soon as possible following admission.

3. *Individuals who wish to enroll in the Choices for Care Medicaid Waiver shall complete an application and file it with DAIL or with the DAIL Long-Term Care Clinical Coordinators in the district offices. If an application is filed in the DAIL central office, it shall be conveyed to the appropriate clinical coordinator as soon as possible.*

4. DAIL requests that a current health and functional assessment be mailed with the application, if available. Assessments may include, but are not limited to, an Independent Living Assessment (ILA), Minimum Data Set (MDS), Residential Care Home Resident Assessment Tool (RCHRAT). Applications will be accepted without a current assessment included.

5. The application for Choices for Care shall consist of the DAIL Choices for Care Program Application related to clinical eligibility and the Department for Children and Families (DCF)'s long-term care Medicaid application form. The applicant may submit the two application forms at the same time or may submit them separately.

B. Applications from Hospitals and Nursing Facilities *(Consistent with Act 123)*

1. Department staff shall provide facilities with information regarding long-term care service options for all individuals whom facility staff believes could benefit from receiving the information.

2. Facility staff shall provide information packets to individuals at the time of admission or as soon as possible following admission.

3. Facility staff shall refer to the Department those individuals who want to apply for Choices for Care waiver services, regardless of what setting they may be interested in (home-based, nursing facility, or enhanced residential care). Applications from hospital settings shall be made as soon as possible following admission.

4. Facility staff shall complete individual assessments according to their internal protocols.

5. Facility staff shall send the assessment data and completed Choices for Care waiver applications to Department staff in a timely manner.

6. Department staff shall make all reasonable efforts to utilize the information available from existing assessments. When possible, Department staff shall determine clinical eligibility for the Choices for Care waiver using existing assessment data.

7. After Department staff receives the completed Choices for Care waiver application and assessment information, he or she shall make reasonable efforts to assess and explain long-term care options, as necessary, to individuals prior to discharge from a hospital. If a face-to-face visit is not possible prior to discharge, Department staff shall make arrangements to see the individual as soon as possible following discharge. In no event shall the application process interfere with a hospital's ability to discharge an individual when the individual no longer needs acute care.

8. Individuals whose skilled care stay exceeds their Medicare-covered benefit must apply and be found eligible for Choices for Care waiver coverage in order to receive a nursing facility Medicaid benefit. Department regional staff shall visit the individual in the facility setting as necessary to assess the individual, determine clinical eligibility, and discuss care/support options.

9. Individuals who exhaust their private resources and any insurance coverage must apply and be found eligible for Choices for Care waiver coverage in order to receive a nursing facility Medicaid benefit.

10. When an individual's circumstances present a clear emergency, and Department staff is unavailable, he or she may be admitted to services without prior approval from the Department. Under these circumstances, the Department shall complete a retrospective review to determine eligibility. If individuals are determined to be ineligible, the Department shall not be responsible for the cost of services received.

C. Initial Screening

DAIL staff will screen application forms for missing/incomplete information. DAIL staff will contact the individual and/or referral source to gather additional information as needed. DAIL staff will contact the individual and/or referral source within three (3) working days.

D. Clinical Assessment

DAIL staff will determine clinical eligibility and category (Highest or High Needs Group) from assessment information submitted with the referral and a face-to-face review. **DAIL staff** will complete an assessment using the "Choices for Care Clinical Assessment" (CFC 802) to determine clinical eligibility. DAIL shall make a decision regarding clinical eligibility for Choices for Care within 30 days of receiving the application.

1. Highest Needs Group: All individuals who apply and meet both the clinical criteria for Highest Need and the financial criteria for Long-term Care (LTC) Medicaid services shall be enrolled in the program. Active program participants who meet the Highest Needs group clinical criteria at reassessment shall not be terminated from services, provided that they continue to meet all other eligibility criteria.

2. High Needs Group: Enrollment in the High Needs group shall be limited by the availability of funds. Individuals who apply and meet both the clinical criteria for the High Needs group and the financial criteria for Long-term Care (LTC) Medicaid services may be enrolled in the program.

a. If funds are unavailable, the names of eligible applicants shall be put on a waiting list. Applicants on a waiting list shall be admitted to the Choices for Care waiver as funds become available, according to procedures established by the Department and implemented by regional Choices for Care waiver teams. The Choices for Care waiver teams shall use professional judgment in managing admissions to the Choices for Care waiver, admitting individuals with the most pressing needs. The teams shall consider the following factors:

i. Unmet needs for ADL assistance;
ii. Unmet needs for IADL assistance;
iii. Behavioral symptoms;
iv. Cognitive functioning;
v. Formal support services;
vi. Informal supports;
vii. Date of application;
viii. Need for admission to or continued stay in a nursing facility;
ix. Other risk factors, including evidence of emergency need; and
x. Priority score.

b. **DAIL staff** shall send a written notice to individuals whose names are placed on a waiting list, which shall include information about how the waiting list operates.

c. When an individual's circumstances present a clear emergency, and **DAIL staff** is unavailable, the individual may be admitted to services without prior approval from the Department. Under these circumstances, DAIL staff shall complete a retrospective review to determine eligibility. Individuals who are determined not to be eligible may be responsible for the costs of services that have been received.

d. All active program participants who meet the High Needs group clinical criteria at reassessment shall continue to be enrolled, provided that they continue to meet all other eligibility criteria. Individuals who are enrolled in the Highest Needs group and subsequently fail to meet the eligibility criteria for the Highest Needs group, but meet the High Needs group eligibility criteria, shall be enrolled in the High Needs group and continue to be eligible to receive services.

e. **DAIL staff** shall review the status of eligible applicants whose names have been on the waiting list for sixty (60) days to ensure that the applicant's needs have not changed.

f. Any eligible applicant whose name has been on the waiting list for 60 days or more shall be given priority for enrollment over eligible applicants with similar needs whose names have been on the waiting list for a shorter amount of time.

E. Financial Assessment

All applicants will be provided with information about the financial eligibility requirements for Choices for Care at the time of the initial application. ***DAIL staff*** *shall provide the DCF Medicaid long-term care eligibility form to any applicant upon request of the applicant or legal representative. Applicants requiring admission or already admitted to a nursing facility or who clearly meet the Highest Needs group clinical eligibility criteria shall be provided the DCF Medicaid long-term care financial*

eligibility form at the same time as the application and shall be encouraged to submit the form as soon as possible.

F. Long-Term Care Options

DAIL staff shall discuss CFC options as part of the application and assessment process. **DAIL staff** will ensure that options brochures and information will be made readily available as needed.

G. Notifications

If the applicant is found clinically eligible for the Highest Needs group, or the High Needs group with funds available, **DAIL staff** will send a Clinical Certification notice to DCF and Choices for Care provider(s). **DCF staff** will then complete the Long-Term Care Medicaid financial eligibility process. If the applicant is found ineligible, **DAIL staff** shall send a written notice with appeal rights.

H. Transitional Service Plan

In addition to the Clinical Certification, **DAIL staff** will create a "Transitional Services Plan" identifying the CFC services and estimated volume of services. DAIL staff will send a copy to all applicable CFC providers. Providers may use this plan to start services pending Long-Term Care Medicaid financial approval. Reimbursement for services provided will not occur until financial eligibility is determined.

I. Final Authorization

When financial eligibility is determined, **DCF staff** will notify DAIL, participant and highest paid provider (if patient share due). If the applicant is found eligible, **DAIL staff** will authorize services and send notification to individual and providers.

J. Transitional Provision

All individuals who are currently being served under a preexisting 1915c Medicaid Waiver (Home-Based or Enhanced Residential Care) or who are receiving Medicaid nursing facility care at the time of the implementation of the Choices for Care waiver shall be enrolled in the Choices for Care waiver and shall continue to receive services. Thereafter, these participants shall continue to be enrolled in Choices for Care if, at reassessment, they meet the eligibility criteria for the Highest Needs group, the High Needs group or the Guidelines for Nursing Home Eligibility adopted in April of 1997.

Attachment F

Vermont Department of Disabilities, Aging and Independent Living

Choices for Care - Clinical Certification

The following individual has applied for Choices for Care and meets the clinical criteria.

I. Individual Information

Name: _____ Phone #: _____

SSN: _____-_____-_____ Date of Birth: _____

Mail Address: _____

Street Address or P.O. Box

_____

Town State Zip

Legal Representative:_____

Address: _____

Relationship to individual: _____ Phone #: _____

Case Management Agency (HB & ERC): _____

II. Clinical Eligibility Status & Setting

Clinical Status: ☐Highest ☐High (funds available)

Choice of Setting: ☐Home ☐Enhanced Residential Care ☐Nursing Facility ☐Hospital Swing Bed

Estimated Length of Stay *(NF or Hospital SB)*: ☐ 30 days or less ☐ Over 30 days

Previous Payor Source *(NF setting only):* Total days at previous payor source:_____
☐Private Pay ☐Medicare ☐Comm. Medicaid ☐VHAP ☐Other

Ins:_____

Highest Cost Provider (*for patient share*):

_____

Requested Start Date:_____ Requested End Date (if any):_____

Est. HB/ERC service cost: $_____/month

III. Long-Term Care Medicaid Financial Application Status

The individual: ☐Has already applied, ☐Has application forms and will apply, ☐Needs application forms, DCF send application to:

_____

Name

_____

Address (if different than applicant/legal rep.)

DAIL Long-Term Care Clinical Coordinator (LTCCC):

Name (print):_____

Signature*:* _____ ***Date***: _____

DAIL #_____

Copy to local DCF/ESD District Office

Attachment G

VERMONT ASSISTED LIVING RESIDENCE AND RESIDENTIAL CARE HOME ASSESSMENT TOOL

NAME OF RESIDENCE:_____

Date of Assessment: (Point of reference for all coding):_____

Date Amended Assessment (significant change in condition): _____

SECTION A: DEMOGRAPHIC INFORMATION

1.**Resident Name**: _____

2. Gender: Female ☐ Male ☐

3. Date of Birth :_____

4. Social Security #:_____

5. Medicare/Medicaid #:_____

6. Other Insurance:_____

7. Date of Admission:_____

8. Physician:_____

9. Physician's Phone:_____

10. Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

11. Admitted from: ☐ Private home or apartment with home health services
☐ Private home or apartment without home health services
☐ Senior housing ☐ Hospital ☐ Assisted Living Residence
☐ Nursing Home ☐ Residential Care Home ☐ Other_____

12. If admitted from hospital, previous or primary residence was (list type of residence from those listed above in #11)_____

13. Name of contact person: _____ Relationship:_____
Address:_____
Home Phone:_____ Work Phone: _____

14. Does the resident have:

	Name	Work Phone	Home Phone
☐ Legal Guardian			
☐ General Power of Attorney			
☐ Representative Payee			
☐ DPOA for Health Care			
☐ Case Manger			

15. Check any of the following that apply:
☐Living Will ☐Do NOT hospitalize ☐Autopsy request ☐Do NOT resuscitate
☐Organ donation ☐Feeding restrictions (please list)_____
☐ Medication restrictions (please list): _____
☐Other treatment restrictions (please list): _____
☐ None of the above
☐ Copy of forms in resident's file

16. Reason for assessment:
☐ Admission ☐ Significant change ☐ Annual assessment ☐ Other (specify):_____

17. Does the resident have allergies?
Food: ☐ Yes ☐ No Medication: ☐ Yes ☐ No

18. Lifetime occupation(s): _____

19. Religious preference: _____

20. Funeral arrangements:_____

Date of Hospitalization: Date of Return:	Date of Hospitalization: Date of Return:
Date of Hospitalization: Date of Return:	Date of Hospitalization: Date of Return:

RECORD STATUS IN LAST 7 DAYS, UNLESS OTHER TIME FRAME INDICATED

SECTION AC: CUSTOMARY ROUTINE

Check all that apply. If all information UNKNOWN, check last box only.

Cycle of Daily Events

A. ☐ Stays up late at night (e.g. after 9 p.m.)
B. ☐ Naps regularly during day (at least 1 hour)
C. ☐ Goes out 1+ days a week
D. ☐ Stays busy with hobbies, reading, or fixed daily routine
E. ☐ Spends most of time alone or watching TV
F. ☐ Moves independently indoors (with appliances, if used)
G. ☐ Use of tobacco products at least daily
H. ☐ NONE OF ABOVE

Eating Patterns

I. ☐ Distinct food preferences
J. ☐ Eats between meals all or most days
K. ☐ Use of alcoholic beverage(s) at least weekly
L. ☐ Eats less than three meals per day. If yes, indicate how many meals taken per day:_____
M. ☐ NONE OF ABOVE

ADL Patterns

N. ☐ In bedclothes much of day
O. ☐ Wakens to toilet all or most nights
P. ☐ Has irregular bowel movement pattern
Q. ☐ Showers for bathing
R. ☐ Bathing in PM
S. ☐ NONE OF ABOVE

Involvement Patterns

T. ☐ Daily contact with relatives/close friends
U. ☐ Usually attends church, temple, synagogue (etc.)
V. ☐ Finds strength in faith
W. ☐ Daily animal companion/presence
X. ☐ Involved in group activities
Y. ☐ NONE OF ABOVE
Z. ☐ UNKNOWN—Resident/family unable to provide information

SECTION B: COGNITIVE PATTERNS

A. Memory (Recall or what was learned or known)

a. Short-term memory OK: seems/appears to recall after 5 minutes. ☐ OK ☐ Problems

b. Long-term memory OK: seems/appears to recall long past. ☐ OK ☐ Problems

B. Memory/Recall Ability
a. ☐ Current season c. ☐ Staff names/faces
b. ☐ Location of own room d. ☐ Current residence e. ☐ NONE OF ABOVE are recalled

C. Cognitive Skills for Daily Decision-Making (Made decisions regarding tasks of daily life)
a. ☐ Independent—decisions consistent/reasonable
b. ☐ Modified independence—some difficulty in new situations only
c. ☐ Moderately impaired—decision poor/cues/supervision required
d. ☐ Severely impaired—never/rarely makes decisions

D. Indicators of Delirium
a. ☐ Easily distracted (e.g. difficulty paying attention; gets sidetracked)
b. ☐ Periods of altered perception or awareness of surroundings (e.g. moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
c. ☐ Episodes of disorganized speech (e.g. speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
d. ☐ Periods of restlessness (e.g. fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
e. ☐ Periods of lethargy (e.g. sluggishness; staring into space; difficult to arouse; little body movement)
f. ☐ Mental function varies over the course of the day (e.g. sometimes better, sometimes worse; behaviors sometimes present, sometimes not)
☐ NONE OF ABOVE

E. Change in Cognitive Status (Resident's cognitive status, skills, or abilities in the last 90 days or since the last assessment)
a. ☐ No change b. ☐ Improved c. ☐ Deteriorated d. ☐ First assessment

SECTION C: COMMUNICATION/HEARING PATTERNS

1. Hearing Patterns
A. ☐ Hears adequately (normal talk, TV, phone)
B. ☐ Minimal difficulty (when not in quiet setting)
C. ☐ Hears in special situations only (speaker has to adjust tonal quality and speak distinctly)
D. ☐ Highly impaired (absence of usual hearing)

2. Communication Devices/Techniques
A. ☐ Hearing aid present and used
B. ☐ Hearing aid present and not used regularly
C. ☐ Other receptive communication techniques used (e.g. lip reading)
D. ☐ NONE OF ABOVE

3. Modes of Expression
A. ☐ Speech
B. ☐ Writing messages to express or clarify needs
C. ☐ American sign language or Braille
D. ☐ Signs/gestures/sounds
E. ☐ Communication board
F. ☐ Other _____
G. ☐ NONE OF ABOVE

4. Making Self Understood

A. ☐ Understood
B. ☐ Usually understood (difficulty finding words or finishing thoughts)
C. ☐ Sometimes understood (ability is limited to making concrete requests)
D. ☐ Rarely/Never understood

5. Ability to Understand

A. ☐ Understands
B. ☐ Usually understands (May miss part/intent of message)
C. ☐ Sometimes understands (Responds to simple/direct communication)
D. ☐ Rarely/Never understands

SECTION D: VISION PATTERNS (Ability to see in adequate light and with glasses if used)

A. ☐ Adequate (sees fine detail, including regular print in newspapers/books)
B. ☐ Impaired (sees large print, but not regular print in newspapers/books)
C. ☐ Moderately impaired (limited vision; not able to see newspaper headlines, but can identify objects)
D. ☐ Highly impaired (object identification in question, but eyes appear to follow objects)
E. ☐ Severely impaired (no vision or sees only light, colors, or shapes; eyes do not appear to follow objects)
F. If resident uses glasses, is resident able to get his/her glasses without assistance? ☐ Yes ☐ No

SECTION E: MOOD AND BEHAVIOR PATTERNS

1. Indicators of Depression, Anxiety, Sad Mood

(Record the appropriate code listed below for the frequency of each symptom observed in last 30 days or since admission, irrespective of assumed cause. List a 0,1, or 2 for each question listed in A-P below.)

0=Indicator not exhibited in last 30 days
1=Indicator of this type exhibited up to 5 days a week
2=Indicator of this type exhibited daily or almost daily (6,7 days a week)

VERBAL EXPRESSIONS OF DISTRESS

A. ____ Resident made negative statement (e.g. "nothing matters"; "would rather be dead")
B. ____ Repetitive questions (e.g. "where do I go?"; What do I do?")
C. ____ Repetitive verbalizations (e.g. calling out for help – "God help me"
D. ____ Persistent anger with self or others (e.g. easily annoyed; anger at placement or care received)
E. ____ Self-deprecation (e.g. "I am nothing"; "I am of no use to anyone")
F. ____ Expressions of fears that appear to be unrealistic (e.g. fear of being abandoned; left alone)
G. ____ Recurrent statement that something terrible is about to happen (e.g. believes s/he is about to die)
H. ____ Repetitive health complaints (e.g. persistently seeks medical attention)
I. ____ Repetitive anxious complaints/concerns (e.g. attention/reassurance regarding schedules, meals etc)

SLEEP-CYCLE ISSUES

J. ____ Unpleasant mood in morning
K. ____ Insomnia/change in usual sleeping pattern

SAD,APATHETIC, ANXIOUS APPEARANCE

L. ____ Sad, pained, worried facial expressions (e.g. furrowed brows)
M. ____ Crying, tearfulness
N. ____ Repetitive physical movement (e.g. pacing, hand wringing, picking)

LOSS OF INTEREST

O. —— Withdrawal from activities of interest (e.g. no interest in long standing activities)
P. —— Reduced social interaction

2. Mood Persistence
One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over the last *7* days. **(Circle correct answer)**
0. No mood indicators
1. Indicators present, easily altered
2. Indicators present, not easily altered

3. Behavioral Symptoms

(A) Problem behavior
0 = behavior not exhibited
1 = behavior of this type occurred less than daily
2 = behavior occurred daily

(B) Behavioral symptom
0 = Behavior was not present OR easily altered
1 = Behavior was NOT easily altered

	(A)	(B)
Wandering (moved with no rational purpose, seemingly oblivious to needs or safety)		
Verbally abusive (others were threatened, screamed at, cursed at)		
Physically abusive (others were hit, shoved, scratched, sexually abused)		
Socially inappropriate/disruptive behavior (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
Resists care (resisted taking medications/injections, ADL assistance, or eating)		

3. Change in Behavioral Symptoms (*Resident's behavior as compared to last assessment):*
☐ No change ☐ Improved ☐ Deteriorated ☐ N/A (initial assessment)

SECTION F: PSYCHOSOCIAL WELL-BEING

1. Sense of Initiative/Involvement *(Check all that apply)*
A. ☐ At ease interacting with others
B. ☐ At ease doing planned or structured activities
C. ☐ At ease doing self-initiated activities
D. ☐ Establishes own goals
E. ☐ Pursues involvement in life of residence (e.g. involved in group activities; responds positively to new activities; assists at religious services)
F. ☐ Accepts invitations into most group activities
G. ☐ NONE OF ABOVE

2. Unsettled Relationships *(Check all that apply)*
A. ☐ Covert/open conflict with or repeated criticism of staff
B. ☐ Unhappy with roommate
C. ☐ Unhappy with residents other than roommate
D. ☐ Openly expresses conflict/anger with family

E. ☐ Absence of personal contact with family/friend
F. ☐ Recent loss of close family member/friend
G. ☐ Does not adjust easily to change in routines
H. ☐ NONE OF ABOVE

3. Past Roles *(Check all that apply)*
A. ☐ Strong identification with past roles and life
B. ☐ Expresses sadness/anger/empty feeling over lost roles/status
C. ☐ Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community
D. ☐ NONE OF ABOVE

SECTION G: PHYSICAL FUNCTIONING

1. (A) ADL Self-Performance (Code for resident's performance over all shifts during last 7 days-Not including setup. **Code for the most dependent in a 24 hour period**.)
0 = Independent: No help or oversight OR Help/oversight provided only 1 or 2 times during last 7 days
1 = Supervision: Oversight, encouragement or cueing provided 3 or more times during last 7 days—OR—Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2 = Limited Assistance: Resident highly involved in activity; received physical help in guided maneuvering of limbs, or other nonweight bearing assistance 3 or more times—OR—More help provided only 1 or 2 times during last 7 days
3 = Extensive Assistance: While resident performed part of activity, over last 7 day period, help of following type(s) provided 3 or more times: Weight bearing support; Full staff performance during part(but not all) of last 7 days
4 = Total Dependence: Full staff performance of activity during entire 7 days

(B) ADL Support Provided (Code **for MOST SUPPORT PROVIDED OVER ALL SHIFTS** during last 7 days; code regardless of resident's self-performance classification) 0 = No setup or physical help from staff 1 = Setup help only 2 = One person physical assist 3 = Two+ persons physical assist	Self-Performance	Support
a. BED MOBILITY: how resident moves to and from lying position, turns side to side, and positions body while in bed		
b. TRANSFER: how resident moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c. WALK IN ROOM: how resident walks between locations in his/her room		
d. WALK IN CORRIDOR: how resident walks in corridor of residence		
e. LOCOMOTION IN RESIDENCE: how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f. LOCOMOTION OUT OF RESIDENCE: how resident moves to and returns from out of residence locations (e.g. areas set aside for dining, activities, or treatment). If residence has only one floor, how resident moves to and from distinct areas on the floor. If in wheelchair, self-sufficiency once in chair		

g. DRESSING: how resident puts on, fastens, and takes off all items of street clothing including donning/removing prosthesis		
h. EATING: how resident eats and drinks (regardless of skill), includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition)		
i. TOILET USE: how resident uses the bathroom (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothing		
j. PERSONAL HYGIENE: how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		
k. CLIMBS STAIRS: how resident climbs stairs **Code N/A <u>Only</u> if facility does not have stairs**		
l. BATHING: how resident takes full body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back & hair)		

2. Body Control

A. ☐ Bedfast all or most of the time
B. ☐ Quadriplegia
C. ☐ Unsteady gait
D. ☐ Hemiplegia/hemiparesis (weakness/paralysis of 1 side)
E. ☐ Amputation
F. ☐ NONE OF ABOVE

3. Modes of Locomotion

A. ☐ Cane/walker/crutch
B. ☐ Wheeled self
C. ☐ Wheelchair primary mode of locomotion
D. ☐ other person wheeled
E. None of Above

4. Modes of Transfer

A. ☐ Bedfast all or most of the time
B. ☐ Lifted manually
C. ☐ Bed rails used for bed mobility or transfer
D. ☐ NONE OF ABOVE
D. ☐ Transfer aid (e.g. slide board, trapeze, cane, walker, brace)
E. ☐ Lifted mechanically

5. Self-Performance in ADLs (*Resident's ADL status or abilities compared to last assessment).*

☐ No change ☐ Improved ☐ Declined ☐ N/A First assessment

6. IADL Self-Performance *(Code for level of independence in the last 30 days based on resident's involvement in the activity) Only Required for ALR*

A. <u>Self-Performance Codes:</u>
0 = Independent: (With/without assistive devices)—No help provided.
1 = Done with help: Resident involved in activity with help, including supervision, reminders, and/or physical help is provided.
2 = Done by others: Full performance of the activity is done by others. The resident is not involved at all when the activity is performed.

B. <u>Support Codes:</u>
0 = No support provided
1 = Supervision/cueing
2 = Set-up only
3 = Physical assistance

IADL	Self	Support

a. Resident arranges for shopping for clothing, snacks or other incidentals.		
b. Resident shops for clothing, snacks, or other incidentals.		
c. Resident arranges suitable transportation.		
d. Resident manages finances: banking, handling checkbook, or paying bills.		
e. Resident manages cash, personal needs allowance.		
f. Resident prepares snacks, light meals.		
g. Resident uses phone.		
h. Resident does light housework, e.g. makes bed, dusts, or takes care of belongings.		

7. Self-Performance in IADLs *(ALR ONLY Resident's IADL status or abilities compared to last assessment)*

☐ No change ☐ Improved ☐ Declined ☐ N/A First assessment

8. ADL and IADL Functional Rehabilitation or Improvement Potential *(Check all that apply)*

A. ☐ Resident believes he/she is capable of increasing independence on at least some ADLs or IADLs.
B. ☐ Direct care staff believe resident is capable of increased independence in at least some ADLs or IADLs.
C. ☐ Resident able to perform tasks/activity but is very slow.
D. ☐ Resident's abilities to perform using these activities differ or vary from morning to evening.
E. ☐ Resident requires or only understands a one-step direction.
F. ☐ Resident requires or only understands no more than a two-step direction.
G. ☐ Resident could be more independent if he/she had special equipment (e.g. cane, walker, plate guard).
H. ☐ Resident could perform more independently if some or all of ADL/IADL activities were broken into subtasks (task segmentation).
I. ☐ Resident could be more independent if he/she received ADL or IADL skills training.
J. ☐ NONE OF ABOVE

9. Transportation

(Check all that apply for the level of independence in the last 30 days based on resident's involvement in the activity.)

A. ☐ Resident drove car or used transportation independently to get to medical, dental appointments, necessary engagements or other activities.
B. ☐ Resident rode to destination with staff, family, others (in car, van, public transportation) but was not accompanied to medical or dental appointments, necessary engagements, or other activities.
C. ☐ Resident rode to destination with staff, family, others (in car, van, public transportation) and was accompanied to medical or dental appointments, necessary engagements, or other activities.
D. ☐ Activity did not occur.

10. Devices Needed *(Check all that apply)*

Resident expresses or gives evidence of needing new, repaired or additional assistive devices.

A. ☐ Eyeglasses
B. ☐ Hearing aid
C. ☐ Cane or walker
D. ☐ Wheelchair
E. ☐ Assistive feeding devices (e.g. plate guard, stabilized built-up utensil)
F. ☐ Assistive dressing devices (e.g. button hook, velcro closings)
G. ☐ Dentures
H. ☐ Other:
I. ☐ NONE OF ABOVE

SECTION H: CONTINENCE IN LAST 14 DAYS

0 = CONTINENT: Complete control
1 = USUALLY CONTINENT: Incontinent episodes once a week or less
2 =OCCASIONALLY INCONTINENT: 2 or more times a week but not daily
3 = FREQUENTLY INCONTINTENT: Tended to be incontinent daily, but some control present
4 = INCONTINENT: Inadequate control, multiple daily episodes

1. Bladder Continence *Control of urinary bladder function (if dribbles, volume is insufficient to soak through underpants) with appliances used (e.g. pads or continence program employed),*	
2. Bowel Continence *(Check only one)* *In last 7 days, control of bowel movement, with appliance or bowel continence programs if employed*	

3. Appliances and Programs *(Check all that apply)*

A. ☐ Any scheduled toileting plan
B. ☐ Bladder retraining program
C. ☐ External (condom) catheter
D. ☐ Indwelling catheter
E. ☐ Intermittent catheter
F. ☐ Did not use bathroom/commode/urinal
G. ☐ Pads/briefs used
H. ☐ Enemas/irrigation
I. ☐ Ostomy present
J. ☐ NONE OF ABOVE

4. Change in urinary continence *(Resident's urinary continence has changed as compared to status of 90 days ago or since last assessment if less than 90 days)*

☐ No change ☐ Improved ☐ Deteriorated ☐ N/A First assessment

5. Use of incontinence supplies *(Check only one) (Resident's management of incontinence supplies, e.g. pads, briefs, ostomy, catheter in last 14 days.)*

A. ☐ Always continent
B. ☐ Resident incontinent and able to manage incontinence supplies independently
C. ☐ Resident incontinent and receives assistance with managing incontinence supplies
D. ☐ Resident incontinent and does not use incontinence supplies

SECTION I. DIAGNOSIS

(Check only those diagnoses that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nurse monitoring, or risk of death and have been documented in the resident's record.)

Do not list inactive diagnoses. If none apply, check the NONE OF ABOVE box.

ENDOCRINE/METABOLIC/NUTRITION

A. ☐ Diabetes mellitus
B. ☐ Hyperthyroidism
C. ☐ Hypothyroidism

HEART/CIRCULATION

D. ☐ Arteriosclerotic heart disease (ASHD)
E. ☐ Cardiac dysrhythmias
F. ☐ Congestive heart failure
G. ☐ Deep vein thrombosis
H. ☐ Hypertension
I. ☐ Hypotension
J. ☐ Peripheral vascular disease
K. ☐ Other cardiovascular disease

MUSCULOSKELETAL

L. ☐ Arthritis
M. ☐ Hip fracture
N. ☐ Missing limb (e.g. amputation)
O. ☐ Osteoporosis
P. ☐ Pathological bone fracture

NEUROLOGICAL

Q. ☐ Alzheimer's disease
R. ☐ Aphasia
S. ☐ Cerebral palsy
T. ☐ Cerebrovascular accident (stroke)
U. ☐ Dementia other than Alzheimer's disease
V. ☐ Hemiplegia/hemiparesis
W. ☐ Multiple sclerosis
X. ☐ Paraplegia
Y. ☐ Parkinson's disease

Z. ☐ Quadriplegia
AA. ☐ Seizure disorder
BB. ☐ Transient ischemic attacks
CC. ☐ Traumatic brain injury

PSYCHIATRIC/MOOD

X. ☐ Anxiety disorder
Y. ☐ Depression
Z. ☐ Manic depressive (Bipolor)
AA. ☐ Schizophrenia
BB. ☐ Mental Illness

PULMONARY

CC. ☐ Asthma
DD. ☐ Emphysema/COPD

SENSORY

EE. ☐ Cataracts
FF. ☐ Diabetic retinopathy
GG. ☐ Glaucoma
HH. ☐ Macular degeneration

OTHER

II. ☐ Allergies/Adverse reactions (specify)
JJ. ☐ Anemia
KK. ☐ Cancer
LL. ☐ Renal failure
MM. ☐ Tuberculosis-TB
NN. ☐ HIV
OO. ☐ Mental retardation (e.g. Down's syndrome, Autism, other organic condition related to Mental Retardation or Developmental disability)
PP. ☐ Substance abuse (alcohol or drug)
QQ. ☐ Other psychiatric diagnosis (e.g. paranoia, phobias, personality disorder)
RR. ☐ Explicit terminal prognosis
SS. ☐ NONE OF ABOVE

INFECTIONS (*Check all that apply)*

A. ☐ HIV Infection
B. ☐ Pneumonia
C. ☐ Respiratory Infection
D. ☐ Septicemia
E. ☐ Urinary tract infection in last 30 days
F. ☐ Wound infection
G. ☐ NONE OF ABOVE

SECTION J: HEALTH CONDITIONS **(***Check all that apply)*

A. ☐ Dehydrated; output exceeds input
B. ☐ Delusions
C. ☐ Hallucinations
D. ☐ Internal Bleeding
E. ☐ Recurrent lung aspirations in last 90 days
F. ☐ Shortness of breath
G. ☐ Vomiting
H. ☐ NONE OF THE ABOVE

STABILITY OF CONDITIONS

A. ☐ Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable – (fluctuating, precarious, or deteriorating
B. ☐ Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem
C. ☐ End-stage disease, 6 or fewer months to live

SECTION K: ORAL/NUTRITIONAL STATUS *(Check all that apply)*

1. Oral Problems

A. ☐ Mouth is "dry" when eating a meal
B. ☐ Mouth pain
C. ☐ Resident has difficulty brushing teeth or dentures
D. ☐ NONE OF ABOVE

2. **Height and Weight (***Record height in inches and weight in pounds. Base weight on most recent measure in last 30 days, or since last assessment; measure weight consistently in accord with standard Residence practice—e.g. in a.m. after voiding, before meal, with shoes off, and in nightclothes.)*

Height:_____ Weight :_____

3. Weight Change

(e.g. 5% or more in a 30 day period or 10% in the past 6 months)

A. Weight Loss ☐ Yes ☐ No ☐ N/A First assessment
B. Weight Gain ☐ Yes ☐ No ☐ N/A First assessment

4. Nutritional Problems

A. ☐ Chewing or swallowing problem
B. ☐ Complains about the taste of many foods
C. ☐ Regular or repetitive complaints of hunger
D. ☐ Leaves 25% or more of food uneaten at most meals

5. Nutritional Approaches

A. ☐ Parenteral IV
B. ☐ Feeding tube
C. ☐ Syringe (oral feeding)
D. ☐ On a planned weight change program
E. ☐ Therapeutic diet
F. ☐ Mechanically altered (or pureed) diet
G. ☐ Noncompliance with diet
H. ☐ Food allergies (specify)_____
I. ☐ Restrictions (specify)_____
J. ☐ NONE OF ABOVE

SECTION L: ORAL/DENTAL STATUS

A. ☐ Debris (soft, easily movable substances) present in mouth prior to going to bed
B. ☐ Has dentures or removable bridges
C. ☐ Some/all natural teeth lost-does not have or does not use dentures (or partial plates)
D. ☐ Broken, loose, or canous teeth
E. ☐ Inflamed gums (gingival; swollen or bleeding gums; oral abscesses; ulcers or rashes)
F. ☐ Daily cleaning of teeth/dentures or daily mouth care- by resident or staff
G. ☐ NONE OF ABOVE

SECTION M: SKIN CONDITION

1. Ulcers *(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). (Code 9 = 9 or more) (Requires full body exam)*

A. _____ **Stage 1**: A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
B. _____ **Stage 2**: A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
C. _____ **Stage 3**: A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue.
D. _____ **Stage 4**: A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

2. Type of Ulcer *(For each ulcer, code for the highest stage using scale in item M1 above—e.g. 0 = none; stages 1,2,3,4)*

A. _____ Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue.
B. _____ Stasis ulcer—open lesion caused by poor circulation in the lower extremities.

3. Other Skin Problems or Lesions Present
A. ☐ Abrasions, bruises
B. ☐ Burns (second or third degree)
C. ☐ Rashes, itchiness, body lice, scabs
D. ☐ Open lesions other than ulcers, rashes, cuts (e.g. cancer lesions)
E. ☐ Skin tears or cuts (other than surgical)
F. ☐ Surgical wounds
G. ☐ NONE OF ABOVE

4. Foot Problems
A. Resident or someone else inspects resident's feet on a regular basis? ☐ Yes ☐ No
B. One or more foot problems or infections such as corns, calluses, bunions, hammer toes, overlapping toes, pain, or structural problem? ☐ Yes ☐ No

5. Skin Treatments
A. ☐ Pressure relieving device(s) for chair
B. ☐ Pressure relieving device(s) for bed
C. ☐ Turning/positioning program
D. ☐ Nutrition or hydration intervention to manage skin problems
E. ☐ Application of dressings (with or without topical medications) other than to feet
F. ☐ Application of ointments/medications (other than to feet)
G. ☐ Other preventative or protective skin care (other than to feet)
H. ☐ Ulcer care
I. ☐ Surgical wound care
J. ☐ NONE OF ABOVE

If any of the above skin treatments are provided by outside resources (e.g. home health agency, PNS, etc) please list here:_____

<u>SECTION N: ACTIVITY PURSUIT PATTERNS</u> - Adapted to resident's current abilities

1. General Activity Preferences *(Check all preferences whether or not activity is currently available to resident)*
A. ☐ Cards/other games
B. ☐ Crafts/arts
C. ☐ Exercise/sports
D. ☐ Dancing
E. ☐ Music
F. ☐ Reading/writing
G. ☐ Spiritual/religious activities
H. ☐ Trips/shopping
I. ☐ Walking/wheeling outdoors
J. ☐ Watching TV
K. ☐ Gardening or plants
L. ☐ Talking or conversing
M. ☐ Helping others
N. ☐ Doing chores around the house/residence
O. ☐ Cooking/baking
P. ☐ Other_____
Q. ☐ NONE OF ABOVE

2. Preferred Activity Settings *(Check all settings at which activities are preferred.)*
A. ☐ Own room
B. ☐ Day/activity room
C. Outside of the residence (e.g. in yard)
D. ☐ Away from residence
E. ☐ NONE OF ABOVE

3. Interaction with Family and Friends

A. How often is resident visited by family or friends?

☐ Daily ☐ Once a week
☐ 2-3 times a week ☐ 1-3 times a month ☐ Never

4. Voting

A. Is resident registered to vote? ☐ Yes ☐ No

5. Social Activities *(Check only one.)*

Resident's current level of participation in social, religious or other personal activities compared to last assessment:

☐ No change ☐ Improved ☐ Declined ☐ N/A First assessment

SECTION O: MEDICATIONS

A. Does the resident take medication? Include over the counter medications. ☐ Yes ☐ No

If yes, answer the next 4 questions. If no, skip to Special Treatments and Procedures.

B. Does the resident know what the medications are for? ☐ Yes ☐ No
C. Does the resident know how to take the medications? (proper route) ☐ Yes ☐ No
D. Does the resident know how often to take the medications? ☐ Yes ☐ No
E. Does the resident communicate if the medication has had the desired effect or unintended side effects? ☐ Yes ☐ No

F. Does the resident control his/her own prescription medications? ☐ Yes ☐ No
G. Does the resident control his/her own over-the-counter medications? ☐ Yes ☐ No
H .Injections: Record the # of days injections of any type received during last 7 days._____

*A **NO** response to any question B. through E. indicates the resident needs medication administration. Inform the registered nurse. Have the nurse review and complete the MEDICATION SECTION.*

I. Who gives the injections? *(Choose one)*

☐ Resident ☐ Home Health
☐ Residence Nurse ☐ Other _____

J. When was the last time the physician reviewed ALL the resident's medications? *(Choose one)*

☐ 1-6 months ☐ 12 months ☐ Over 1 year ☐ Unknown

K. Medication Compliance *(Resident's level of compliance with medications prescribed by a physician/psychiatrist during last 30 days or since admission.)*

☐ Always compliant
☐ Compliant some of the time (80% of the time or more often) or with some medications.
☐ Rarely or never compliant

L. Record the number of days during the last 7 days any of the following medications were used.; "0" if not used.

____ Anti-psychotic ____ Anti-depressant ____ Diuretic
____ Anti-anxiety ____ Hypnotic

SECTION P: SPECIAL TREATMENTS AND PROCEDURES

1. Special Treatments, Procedures and Programs

a. SPECIAL CARE—*Check treatments or programs received during the last 14 days.*

TREATMENTS

A. ☐ Chemotherapy
B. ☐ Dialysis
C. ☐ IV medication
D. ☐ Intake/output
E. ☐ Monitoring acute medication condition
F. ☐ Ostomy care
G. ☐ Oxygen therapy
H. ☐ Radiation
I. ☐ Suctioning
J. ☐ Tracheostomy care
K. ☐ Transfusions
L. ☐ Ventilator or respirator

PROGRAMS

L. ☐ Alcohol/drug treatment program
M. ☐ Alzheimer's/dementia special care unit
N. ☐ Hospice care
O. ☐ Home health
P. ☐ Home care
Q. ☐ Training in skills required to return to the community (e.g. taking medications, house work, shopping, transportation, ADLs)
R. ☐ Case management
S. ☐ Day treatment program
T. ☐ Sheltered workshop/employment
U. ☐ Transportation
V. ☐ Psychological rehabilitation
W. ☐ Respite
X. ☐ NONE OF ABOVE

b. **THERAPIES**-- Record the number of days the following therapies were administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 minutes a day)
(A) = # of days administered for 15 minutes or more
(B) = total # of minutes provided in the last 7 days

Therapy	Days (A)	Minutes (B)
a. Speech –language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

2. Special Programs for Mood, Behavior and Cognitive Loss

A. ☐ Special behavioral symptom management program: a program of ongoing, comprehensive, interdisciplinary evaluation of behavioral symptoms. The purpose of such a program is to attempt to understand the "meaning" behind the resident's behavioral symptoms in relation to the resident's health and functional status, and social and physical environment. The ultimate goal of the evaluation is to develop and implement a plan of care that serves to reduce distressing symptoms.

B. ☐ Special behavioral management program: includes resident-specific changes in the environment to address mood/behavior/cognitive patterns. Examples include placing a banner labeled "wet paint" across a closet door to keep the resident from repetitively emptying all the clothes out of the closet, or placing a bureau of old clothes in an alcove along a corridor to provide diversionary "props" for a resident who frequently stops wandering to rummage. Reorientation includes individual or group sessions that aim to reduce disorientation in confused residents, including environmental cueing in which all staff involved with the resident provide orienting information and reminders.

C. ☐ Evaluation by a licensed mental health specialist since last assessment: an assessment of a mood, behavior disorder, or other mental health problem by a qualified clinical professional such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker. Do not check this item for routine visits by the residence social worker.

D. ☐ Group therapy: resident regularly attends sessions at least weekly. Therapy is aimed at helping to reduce loneliness, isolation, and the sense that one's problems are unique and difficult to solve. The session may take place either at the residence or outside the residence.

E. Other
_____

F. ☐ NONE OF ABOVE

3. Rehabilitative/Restorative Care *(Record the number of days each of the following rehabilitative or restorative techniques or practices was provided to the resident for* ***more than or equal to 15 minutes per day*** *in the last 7 days). Enter 0 if none or less than 15 minutes daily.*

A. —— Range of motion (passive)
B. —— Range of motion (active)
G. —— Dressing or grooming
H. —— Eating or swallowing

C. ____ Splint or brace assistance

TRAINING/SKILL PRACTICE IN:

D. ____ Bed mobility

E. ____ Transfer

F. ____ Walking

I. ____ Amputation/prosthesis care

J. ____ Communication

K. ____ Other (specify)_____

L. ____ NONE OF ABOVE

4. Skills Training *(Record the number of days, in the last 30 days that each of the following IADLs were performed with assistance from staff as a skill training activity identified in the resident's service plan.)*

SKIP IF THE IADL SECTION, PAGE 8 WAS NOT COMPLETED.

A. ____ Meal preparation (snacks, light meals)
B. ____ Telephone use
C. ____ Light housework (makes own be, takes care of belongings)
D. ____ Laundry (sorts, folds, or washes own laundry)
E. ____ Managing incontinence supplies (pads, briefs, ostomy, catheter)
F. ____ Managing cash (handles cash, makes purchases)
G. ____ Managing finances (banking, handling checkbook or savings account)
H. ____ Arranges shopping (makes list, acquires help)
I. ____ Shopping (for groceries, clothes, or incidentals)
J. ____ Transportation (travel by various means to get to appointments or necessary engagements)
K. ____ Medications (preparation and administration of medications)

5. Visiting Nurse/Home Health Therapies

Has the resident received care or services from a home health nurse or aide since the last assessment?

☐ Yes ☐ No ☐ N/A First assessment

If yes, check all that apply:

	Less than once a week	Once a week	More than once/week
Nurse	_____	_____	_____
Nurse aide	_____	_____	_____

6. Devices and Restraints *(Codes: 0=not used; 1=used less than daily; 2 = used daily)*

A. ____ Full bed rails on all open sides of bed
B. ____ Trunk restraint
C. ____ Other types of side rails, e.g. half, etc.
D. ____ Chair prevents rising
E. ____ Limb restraint

SECTION Q: DISCHARGE POTENTIAL

A. Does resident or family indicate a preference for another living arrangement? ☐ Yes ☐ No

B. Does resident have a support person who is positive towards discharge? ☐ Yes ☐ No

C. Stay projected to be of a short duration—discharge projected within 90 days? ☐ Yes ☐ No

D. Has resident' self-sufficiency changed compared to last assessment?

☐ No change ☐ Improved (receives fewer supports, needs less restrictive plan of care)

☐ Deteriorated (receives more support) ☐ N/A First assessment

NOTES:_____

_____

_____

_____

_____

_____

_____

SECTION R: ASSESSMENT INFORMATION *(Check all that participated in the assessment process)*

1. Participation in Assessment

A. ☐ Resident
B. ☐ Family
C. ☐ Legal representative
D. ☐ Caregiver
E. ☐ Case manager
F. ☐ Other_____

2. SIGNATURES OF PERSONS COMPLETING ASSESSMENT:

A. Person completing assessment *(required)*

_____

Signature **Title** **Date**

B. Resident or legal representative

_____

Signature **Date**

C. Facility Registered Nurse *(required)*

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment.

_____

Signature **Date**

D. Other Signatures

_____

Signature **Date**

SUPPLEMENTAL BEHAVIOR AND COGNITION INFORMATION

BEHAVIOR

Please check the description that most accurately describes the resident's behavior:

1. Sleep Pattern

☐ Unchanged from "normal" for the resident.
☐ Sleeps noticeably more or less than "normal".
☐ Restless, nightmares, disturbed sleep, increased awakenings.
☐ Up wandering for all or most of the night, inability to sleep.

2. Wandering

☐ Does not wander.
☐ Does not wander. Is chair-bound or bed-bound.
☐ Wanders within the residence any may wander outside but does not jeopardize health and safety.
☐ Wanders within the residence. May wander outside, health and safety may be jeopardized. Does not have history of getting lost and is not combative about returning.
☐ Wanders outside and leaves grounds. Has a consistent history of leaving grounds, getting lost or being combative about returning. Requires a treatment plan that may include the use of psychotropic drugs for management and safety.

3. Behavioral demands on others

☐ Attitudes, habits and emotional states do not limit the individual's type of living arrangement and companions.
☐ Attitudes, habits and emotional states limit the individual's type of living arrangement and companions.
☐ Attitudes, disturbances and emotional states create consistent difficulties that are not modifiable to manageable levels. The individual's behavior cannot be changed to reach the desired outcome through respite, existing residence staff, even given staff training.

4. Danger to self and others

☐ Is not disruptive or aggressive and is not dangerous.
☐ Is not capable of harming self or others because of mobility limitations (is bed-bound or chair-bound)
☐ Is sometimes (1-3 times in the last 7 days) disruptive or aggressive either physically or verbally or is sometimes extremely agitated or anxious even after proper evaluation and treatment
☐ Is frequently (4 or more times during the last 7 days) disruptive or aggressive or is frequently extremely agitated or anxious and professional judgment is required to determine when to administer prescribed medication
☐ Is dangerous or physically abusive and even with proper evaluation and treatment may require physician's orders for appropriate intervention

5. Awareness of needs/Judgments

☐ Understands those needs that must be met to maintain self care

☐ Sometimes (1-3 times in the last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation
☐ Frequently (4 or more times during the last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation
☐ Does not understand those needs that must be met for self care and will not cooperate even though given direction or explanation

COGNITION

Please check the description that most accurately describes the resident's behavior:

1. Memory for events

☐ Can recall details and sequences of recent experiences and remember names of meaningful acquaintances
☐ Cannot recall details or sequences of recent events or remember names of meaningful acquaintances
☐ Cannot recall entire events (e.g. recent outings, visits of relatives or friends) or names of close friends or relatives without prompting
☐ Cannot recall entire events or name of spouse or other living partner even with prompting

2. Memory and use of information

☐ Does not have difficulty remembering and using information. Does not require directions or reminding from others
☐ Has minimal difficulty remembering and using information. Requires direction and reminding from other 1 to 3 times per day. Can follow simple written instruction.
☐ Has difficulty remembering and using information. Requires direction and reminding from others 4 or more times per day.
☐ Cannot remember or use information. Requires continual verbal reminding.

3. Global confusion

☐ Appropriately responsive to environment.
☐ Nocturnal confusion on awakening.
☐ Periodic confusion during daytime.
☐ Nearly always confused.

4. Spatial orientation

☐ Oriented, able to find and keep his/her bearings.
☐ Spatial confusion when driving or riding in local community.
☐ Gets lost when walking in neighborhood.
☐ Gets lost in residence or present environment.

Attachment H – Termination Procedures and Change Report Form

Denial and Termination Procedures

A. Voluntary Withdrawal

An applicant may voluntarily withdraw her/his application for Choices for Care (CFC) services or participation in CFC services at any time for any reason using the following procedures:

1. The **individual** shall inform the case manager or provider of her/his decision to withdraw from CFC services.

2. A "Change Report" form must be completed and sent to DAIL and DCF indicating the reason for termination and that it is a voluntary withdrawal.
   a. The **case manager** completes the "Change Report" form for home-based and ERC setting.
   b. The **nursing facility provider** completes the "Change Report" form for nursing facility setting.

B. Denials and Terminations

New applicants may be denied eligibility and active participants may be terminated from CFC services for the following reasons:

1. Clinical ineligibility: **The Department of Disabilities, Aging and Independent Living (DAIL) staff** will determine clinical eligibility. If found ineligible at any time, **DAIL staff** will send a written notice of ineligibility to the individual and DCF with appeal rights.

2. Financial ineligibility: The **Department for Children and Families** (**DCF) staff** will determine financial eligibility. If the individual is found financially ineligible at any time, **DCF will** send a written notice of ineligibility to the individual and DAIL staff, including appeal rights.

3. Participant death: If the individual dies, a "Change Report" form must be completed and sent to DAIL and DCF.
   a. The **case manager** completes the form for the Home-Based and Enhanced Residential Care (ERC) setting.
   b. The **nursing facility provider** completes the form for nursing facility setting.

4. Permanent move out of state: If the individual permanently moves out of the state, a "Change Report" form must be completed and sent to DAIL and DCF. **DAIL staff** will send a written notice of ineligibility with appeal rights to the individual and DCF if the denial or termination is involuntary.
   a. The **case manager** completes the "Change Report" form for home-based and ERC setting.
   b. The **nursing facility provider** completes the "Change Report" form for nursing facility setting.
5. Stay out of state-exceeding 30 continuous days: If the individual leaves the state for more than 30 continuous days, a "Change Report" form must be completed and sent to DAIL and DCF. **DAIL staff** will send a written notice of ineligibility with appeal rights to the individual and DCF if the denial or termination is involuntary.
   a. The **case manager** completes the "Change Report" form for home-based and ERC setting.
   b. The **nursing facility provider** completes the "Change Report" form for nursing facility setting.

6. The individual no longer requires CFC services to remain in setting of choice: If the case manager or provider(s) has evidence which leads him or her to believe that the individual no longer requires CFC services to remain in the setting of their choice, a "Change Report" form must be completed and sent to DAIL and DCF. **DAIL staff** will send a written notice of ineligibility with appeal rights to the individual and DCF if the denial or termination is involuntary.
   a. The **case manager** completes the "Change Report" form for home-based and ERC setting.
   b. The **nursing facility provider** completes the "Change Report" form for nursing facility setting.

7. Provider termination of services: In limited situations, a CFC **provider** may terminate services for the following reasons:
   a. Non-payment of patient share by the individual or legal representative.
   b. Dangerous environment placing staff at risk of physical harm.
   c. Involuntary discharge from residential setting (ERC or nursing facility) according to DLP Licensing Regulations. *This does not include a voluntary transfer of setting within CFC services.*

   It is expected that **the provider** will make all reasonable attempts to remedy the situation prior to termination of services. Efforts may include, but are not limited to, negotiated risk contracts, involvement of Adult Protective Services, family care conferences, and interdisciplinary team meetings. Efforts must be clearly documented and **the provider** must contact DAIL staff and the case manager (when applicable), prior to termination. Once a decision to terminate services has been made, **the provider** must send a written notice to the individual explaining the reasons for termination. Licensed facilities (ERC and NF) must follow existing regulations regarding discharge notices.

   If **the provider** has terminated services, the situation is not remedied after 30 days, and other CFC services are not being successfully utilized, the individual may be terminated from CFC services. The provider must consult with DAIL staff prior to termination. A "Change Report" from must be completed and sent to DAIL. **DAIL staff** will send a

written notice with appeal rights to the individual and DCF if the denial or termination is involuntary.

a. The **case manager** completes the "Change Report" form for home-based and ERC setting.
b. The **nursing facility provider** completes the "Change Report" form for nursing facility setting.

CHANGE REPORT FORM
Choices for Care, VT Long-Term Care Medicaid Program

Complete this form when reporting changes for active Choices for Care participants. See back for instructions.

Individual Name: _____SSN: _____

Address: _____Phone#:_____ _____

☐**Check if *new* address/effective date:** _____
☐**Check if *new* Patient Representative Name & Address:**_____

_____

A. Transfer of Setting *Send a copy to local DAIL office and DCF/ESD office.*

Effective date of transfer: _____ ☐**Temporary** or ☐ **Permanent**

NEW **Setting *(check one)*:**
☐***Home-Based**
☐***ERC: (provider name)**_____
☐**Nursing Home: (provider name)**_____
☐**Hospital Swing-Bed: (provider name)**_____

*NOTE: **For changes from Nursing Home or Hospital Swing Bed to Home-Based or ERC, the individual must choose a Case Management agency. Choose one:**
☐**Area Agency on Aging** *-OR-* ☐**Home Health Agency**

B. Nursing Home/Hospital Swing-Bed Changes *Send a copy to local DCF/ESD office and OVHA.*

☐**Admission to Hospital date:** _____
Hospital:_____
Bed hold? ☐**Yes** ☐**No** **Estimated return date (if known):** _____
☐**Readmission from hospital date:** _____ **/# of days in hospital**_____
Payor source upon readmission:_____
☐**MEDICARE to Medicaid effective date:** _____**/# of Medicare days used** _____
☐**Medicaid to MEDICARE effective date:** _____
☐**Co-insurance Medicare patient effective date:** _____ **through** _____
☐**Hospice effective date:** _____

C. Termination from Choices for Care ***(check one)*** *Send a copy to local DAIL and DCF/ESD office.*

Effective date: _____ *For Nursing Home residents, a copy must also go to OVHA.*

☐ **Died**
☐ **Permanent move out of state**
☐ **Stay out of state exceeding 30 continuous days**
☐ **No longer require Choices for Care services (condition has improved or other services meeting needs)**
☐ **Other:**

_____

Is the termination (other than death) a voluntary withdrawal? ☐ ***Yes** ☐ **No**

*If "Yes", the individual or legal representative must sign below agreeing to the termination. Individuals who are involuntarily terminated from Choices for Care will receive a written notice with appeal rights.

I agree that I am voluntarily withdrawing from Choices for Care for reasons noted above. I may reapply at any time.

_____ _____

Individual or Legal Representative Signature **Date**

Person Completing Form (print):
_____

Agency/Provider name: _____
Phone number:_____

Signature: _____
Date: _____

WHO COMPLETES THIS FORM?

This form is used to report changes for active Choices for Care participants **only. When completing the Change Report Form, complete all sections that apply.**

- Case Manager in Home-Based or ERC Setting: **In the home-based setting and the ERC setting, the Choices for Care case manager is responsible for completing this form for:**
  - **Transfer of Setting (Section A)**
  - **Termination (Section C)**

- Hospital Swing-Bed Provider: **For active Choices for Care participants moving into an approved hospital swing-bed from any setting, the hospital provider completes form for:**

- **Transfer of Setting (Section A)**
- **Nursing Facility/Hospital Swing-Bed Changes (Section B)**
- **Termination (Section C)**

NOTE: This form replaces the 281 form for Hospitals.

➢ Nursing Facility Provider: **In the nursing facility setting the nursing facility provider completes the form for:**

- **Transfer of Setting (Section A)**
- **Nursing Facility/Hospital Swing-Bed Changes (Section B)**
- **Termination (Section C)**

NOTE: This form replaces the 280 form for nursing facilities.

TYPES OF CHANGES

A. Transfer of Setting: **Must be completed for active Choices for Care participants who are changing Choices for Care, long-term care settings. Effective date is the date the individual moves to the new setting. If the individual intends to return to their previous setting, indicate "Temporary". If the new setting is a permanent change, indicate "Permanent". Case management agency must be chosen for individuals moving from a nursing facility setting into the home-based or ERC setting.** *Send a copy to local DAIL and DCF/ESD office.*

B. Nursing Facility Changes: **Must be completed for active Choices for Care participants residing in a nursing facility who have a hospital admission, readmission from hospital, or change in payor source. (NOTE: replaces 280 for nursing facilities)** *Send a copy to local DCF/ESD office and OVHA.*

C. Termination from Choices for Care: **Must be completed when an active Choices for Care participant terminates from the program for any reason. The individual or legal representative must sign the termination if it is a "voluntary withdrawal". This does not include transfers between Choices for Care settings.** *Send a copy to local DAIL, DCF/ESD office*

CONTACTS

DAIL: Contact regional DAIL office.
DCF: Contact regional DCF/ESD office.
OVHA: **Office of Vermont Health Access, 312 Hurricane Lane, Suite 201, Williston, VT 05495**
PHONE: **(802) 879-5900** FAX: **(802) 879-5919**

Attachment I

Choices for Care
Vermont Long-Term Care Medicaid

Consumer and Surrogate Directed Services
Employer Handbook

DRAFT April 2004

Vermont Agency of Human Services
Department of Aging and Independent Living
Division of Disability and Aging Services
102 South Main Street
Waterbury, Vermont 05671-2301
802-241-2400 (voice/ttd) 802-241-2325 (fax)

www.dad.state.vt.us

This document is available in alternative format upon request.

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CHAPTER I: Introduction

The Vermont Department of Aging and Independent Living (DAIL) manages the "Choices for Care", Vermont Long-Term Care Medicaid (LTCM) program. The goal of this program is to offer eligible elders and adults with physical disabilities a choice of long-term care services in the setting they choose.

In the Home-Based setting, the LTCM program offers three services that may be directed by the participant (consumer-directed) or a surrogate (surrogate-directed). These services include:

- Personal Care
- Respite Care
- Companion Services

Being an **EMPLOYER** is a big responsibility and should not be taken lightly. If an individual who is participating in the LTCM program is able and willing to be an **EMPLOYER** for Personal Care, Respite or Companion services, they may apply for the consumer-directed option. However, if the individual is not able or willing to be the employer, a trusted friend or family member may apply to be the surrogate-directed **EMPLOYER**.

Whether consumer or surrogate directed, the LTCM case manager must certify the prospective **EMPLOYER**. Once certified, the **EMPLOYER** agrees to perform all activities required to hire, train, and supervise personal care attendants, respite and/or companion employees. This manual will help **EMPLOYERS** understand their responsibilities as well as the LTCM program requirements.

CHAPTER II: Eligibility

1. Program Eligibility

To be eligible for the "Choices for Care", Vermont Long-Term Care Medicaid (LTCM) program, an individual must:

a) be a Vermont resident;
b) be at least 65 years of age, or 18 or older and have a physical disability;
c) be financially eligible for Long-Term Care Medicaid;
d) meet the clinical criteria;
e) make an informed choice to accept LTCM services in a Service Plan.

Individuals who wish to direct their own services must also meet the following **EMPLOYER** eligibility guidelines.

2. Employer Eligibility

The LTCM case manager must certify any individual who wishes to be a consumer or surrogate-directed **EMPLOYER.** As a part of this process the case manager will complete an "Employer Certification Form".

All consumer or surrogate-directed **EMPLOYERS** must have the cognitive ability to communicate effectively and perform the activities required of an employer. Cognition and communication are defined as follows:

a. Cognition: the ability to understand and perform the tasks required to employ a caregiver (including recruitment, hiring, scheduling, training, supervision, and termination). An individual who has cognitive impairments or dementia that prevent understanding and performance of these tasks, is not competent, or has a guardian, is not eligible to manage waiver services.

b. Communication: the ability to communicate effectively with the case manager and with the caregiver(s) in performing the tasks required to employ a caregiver. An individual, who cannot communicate effectively, whether through verbal communication or alternate methods, is not eligible to manage waiver services.

If the individual or surrogate is not able or willing to be the **EMPOYER**, the case manager will discuss other options.

CHAPTER III: Program Limitations

The "Choices for Care", Vermont Long-Term Care Medicaid (LTCM) program has the following limitations under the consumer/surrogate directed option:

1. Consumer and surrogate employers are **not** paid by the LTCM to direct and manage services.

2. An individual's legal guardian (appointed by a probate court) may **not** be paid to provide services under LTCM. The Department of Aging and Independent Living (DAIL) may grant variances to this limitation on a case-by-case basis. The case manager must send variance requests to DAIL in writing.

3. An employee who is paid by LTCM to provide services for the individual may **not** also serve as the surrogate employer.

4. LTCM only provides services and care for the individual who has been found eligible. Therefore, services are **restricted to the benefit of the individual.**

5. Persons with a substantiated history of abuse, neglect, or exploitation (included in the Vermont Adult Abuse Registry, or similar registry) may **not** be paid to provide any services under LTCM. The payroll agent will check the Adult Abuse Registry in DAIL for the names of all such current or prospective employees.

6. An individual's spouse or civil union partner may **not** be paid to provide services under the Medicaid Waiver program.

7. Employees are not paid to provide services while the individual is admitted to a hospital or nursing facility.

8. Individuals may remain eligible for LTCM up to **30 days** while absent from the state of Vermont.

9. Individuals may use their LTCM services up to **7 days** while absent from the state of Vermont.

10. Surrogate employers shall not be certified to manage LTCM services for more than two (2) individuals at one time.

11. LTCM shall not be used to provide services that are otherwise being purchased privately or through another funding source.

CHAPTER IV: Service Descriptions

"Choices for Care", Vermont Long-Term Care Medicaid (LTCM) covers the following consumer and surrogate-directed services in the Home-Based setting.

1. Personal Care Services

Personal Care Services may include help with the following:

- Dressing
- Bathing
- Grooming (help with brushing teeth, shaving, hair and skin care)
- Bed mobility (moving about while in bed)
- Toilet use
- Personal hygiene and clean up related to incontinence
- Assistance with adaptive devices
- Transferring (help getting to and from chair and bed)
- Mobility (help with walking or using a wheelchair)
- Eating

When needed, services may also include the following **for the individual only**:

- Help using the telephone
- Preparing meals
- Heavy housekeeping: for example, mopping floors and taking out garbage
- Light housekeeping: for example, changing the bed, dusting, vacuuming and doing laundry
- Shopping
- Travel assistance necessary for the person's health and welfare
- Care of adaptive equipment

The case manager together with the participant completes a **"Personal Care Worksheet" and "Service Plan**". The case manager will provide the **EMPLOYER** with a copy of the Personal Care Worksheet. The Personal Care Worksheet describes the specific tasks and services that shall be provided for the individual. The Service Plan identifies the overall type and amount of services the individual has been approved to receive. The Personal Care Worksheet and

Service Plan shall be used by the **EMPLOYER** to plan service schedules and approve timesheets.

2. Respite Care Services

Respite Care services are designed to provide a break or relief from care to the individual's primary, unpaid caregiver (e.g. spouse). Respite Care services are based on blocks of time, rather than on specific tasks. Respite Care may include supervision as well as the specific tasks described under Personal Care services. Only individuals who have an unpaid primary caregiver are eligible to receive Respite Care services. A maximum of **720 hours a calendar year** is available. If the individual also receives Companion services, the combined total may not exceed 720 hours a calendar year.

3. Companion Services

Companion services include non-medical care, supervision and socialization. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities on an ongoing basis. A maximum of **720 hours a calendar year** is available. If the individual also receives Respite Care services, the combined total may not exceed 720 hours a calendar year.

CHAPTER V: How to Apply and Enroll

Once an applicant has been enrolled in Vermont Long-Term Care Medicaid (LTCM), a case manager will assess their needs and assist the applicant through the process. The following outlines the steps involved with certifying **EMPLOYERS**, enrolling **EMPLOYERS** and **EMPLOYEES**.

1. Certification of Employer Eligibility

All consumer or surrogate directed **EMPLOYERS** must be certified as able and willing to direct Medicaid Waiver services.

a. Certification
During the initial assessment process, the case manager completes an "Employer Certification Form". The case manager must verify and document that the prospective consumer or surrogate employer is able (as described under "Eligibility") and willing to direct and manage services. By signing the Service Plan and Employer Agreement form the **EMPLOYER** agrees to perform the required activities. The case manager will continue to monitor the employer's ongoing eligibility during monthly contact and annual reassessments.

b. Non-Certification
If the case manager determines that the consumer or surrogate is not able to perform the ongoing tasks required as the **EMPLOYER**, the individual shall be notified of the decision in writing. The notice will include appeal rights.

2. Enrolling Employers

Once certified, the consumer and surrogate directed **EMPLOYERS** must enroll in the payroll system as described below:

a. **Contact Payroll Agency:** Certified **EMPLOYERS** must contact the following payroll agent to obtain the necessary forms to become enrolled in the payroll system:

ARIS
PO BOX 4409
White River Junction, VT 05001
1-800-798-1658

b. **EMPLOYER Forms:** The following forms must be completed by the **EMPLOYER** and returned to the payroll agent in order to enroll in the payroll system:

- Form 2678 Employer Appointment of Agent Form (IRS # 2678)
- Consumer/Surrogate Directed Employer Agreement Form
- Worker's Compensation Authorization Form
- Power of Attorney Form
- Consumer Information Form

Important: Timesheets cannot be processed, nor can payments to workers be made, until all of these forms have been received and processed by the payroll agent.

3. Enrolling Employees

Once the employer has located a suitable **EMPLOYEE(S),** the **EMPLOYEE** must complete the following forms and return to the payroll agent. **This applies to both new employees *and* returning employees who have not been employed by the consumer in the current calendar year:**

- Form W-4 Employee's Withholding Allowance Certificate
- Form I-9 Employment Eligibility Verification Form
- Record Check Release Form Vermont Criminal Information Center
- Consent for Release of Information Adult Protective Services
  - Background Check Release Form
  - Optional: Form W-5 Earned Income Credit Advance Payment Certificate
  - Optional: Direct Deposit Form

Important: Timesheets cannot be processed, nor can payments to workers be made, until all of these forms (not including optional forms) have been received and processed by the payroll agent.

EMPLOYERS should notify their employees that there may be a delay of several weeks before the first paycheck is issued. **EMPLOYERS** may wish to discuss this issue with the LTCM case manager, as well.

CHAPTER VI: Employer Responsibilities

1. Employer Responsibilities

The "Choices for Care", VT Long-Term Care Medicaid (LTCM) consumer/surrogate directed services are a wonderful option for many people. However, this option is not suited for everyone. Being an **EMPLOYER** is an important responsibility and should not be taken lightly. Please consider the following responsibilities before enrolling as an **EMPLOYER**.

The consumer or surrogate **EMPLOYER** must agree to perform the following ongoing tasks:

- Understand and follow program requirements
- Recruit and select employee(s)
- Notify selected employee(s) of their responsibilities
- Assure that employment forms are completed and submitted to the payroll agent (See Chapter VIII)
- Train employee(s) to perform specific tasks as needed
- Develop a work schedule based on the approved Service Plan
- Maintain updated copies of approved waiver Service Plan
- Arrange for substitute or back-up employees as needed
- Develop and maintain a list of tasks for the employee(s) to perform based on the Personal Care Worksheet
- Authorize employee(s) timesheets (based on the approved Service Plan and actual time worked)
- Maintain copies of all employee(s) timesheets
- Supervise employee(s) at least every sixty (60) days to assure that tasks are performed correctly and completely
- Evaluate employee(s) performance
- Provide ongoing performance feedback to employee(s)
- Terminate employee(s) employment when necessary
- Notify the payroll agent of any necessary changes
- Participate in the assessment and reassessment of LTCM eligibility
- Communicate with the case manager on a regular basis (See Chapter IX.)
- If applicable, assure a monthly patient share is paid to the payroll agent (See Chapter VIII.)

- Track use of Respite and Companion service hours, so as not to exceed 720 hours a calendar year (See Chapter IV)
- Avoid conflict of interest with employees, participant and/or other participating agencies

Surrogate employers must be **available** to perform the above employer responsibilities on an ongoing basis.

2. How to Find and Keep a Caregiver

EMPLOYERS may to refer to the **"Help at Home: A Guide to Finding and Keeping Your Caregiver"** (published by Homeshare Vermont, Burlington, VT), for helpful information and tips on hiring, training and keeping caregivers/workers. **EMPLOYERS** may obtain a guide by contacting the Medicaid Waiver case manager or Homeshare Vermont at (802) 863-5625 or http://www.homesharevermont.org/.

CHAPTER VII: Employee Eligibility and Restrictions

1. Employee Eligibility

All **EMPLOYEES** must be legally eligible for employment under state and federal laws. In addition, for the Long-Term Care Medicaid (LTCM) program, eligible **EMPLOYEES** must:

- be aged 18 or over
- have a high school degree or equivalent
- be legally eligible to work in the state of Vermont

On a case-by-case basis, the Department of Aging and Independent Living (DAIL) may approve an employee to provide services when the employee has an equivalent combination of education, experience, and skill specific to working with elders with functional limitations or individuals with disabilities. Requests must be presented in writing to DAIL.

2. Employee Restrictions

The following restrictions apply to all **EMPLOYEES**:

- Persons with a substantiated history of abuse, neglect, or exploitation (included in the Vermont Adult Abuse Registry, or similar registry) may **not** be paid to provide any services under LTCM. The payroll agent (ARIS) will check the Adult Abuse Registry in DAIL for the names of all such current or prospective employees.

- The spouse or civil union partner of the individual may **not** be paid to provide any services through LTCM for care of the individual.

- An individual's legal guardian (appointed by a probate court) may **not** be paid to provide services under LTCM. The Department of Aging and Independent Living (DAIL) may grant variances to this limitation on a case-by-case basis. Variance requests must be sent to DAIL in writing.

- A participant's Surrogate **EMPLOYER** may **not** also be a paid **EMPLOYEE** for any services under LTCM.

CHAPTER VIII: Payroll Policies and Procedures

1. Payroll Agent

Payroll services are provided by the Long-Term Care Medicaid (LTCM) program, through a contracted payroll agency. The payroll agent will process timesheets, paychecks and taxes, maintain individual employment tax records for workers and perform related payroll activities, including background checks for substantiated incidents of abuse, neglect, or exploitation of others and for criminal records.

The payroll agent for the LTCM is:

Area Resource for Individualized Services (ARIS)
P.0. BOX 4409
White River Junction, VT 05001
1-800-798-1658

The payroll agent will provide employers and employees with:

- All of the necessary employment forms,
- Timesheet forms,
- Pre-stamped addressed envelopes for mailing timesheets to the payroll agent,
- Annual W-2 tax statements to employees
- Instructions and technical assistance in completing forms

2. Submitting Timesheets

All employee timesheets must be submitted in the following manner:

- The timesheet must be completed correctly, including the dates and times of service.
  - The employer must sign the timesheet to verify that services were received.
  - The timesheet must be completed correctly, and legibly, including the signatures of both the employee and the employer.

- The timesheet must be submitted to the payroll agent according to the payroll schedule (See appendix).
- **NOTE:** ARIS will not accept **FAXED** timesheets.

***Important:* Neither DAIL nor the payroll agent are responsible for delays in payment caused by late submissions, incomplete or illegible forms, or neglect of the consumer/surrogate or worker to inform the payroll agent of changes in address, etc.**

3. Additional Employees or Replacement of Employees

All new **EMPLOYEES** must complete the employment enrollment process prior to receiving any paychecks. There are no exceptions to this policy.

4. Termination of Employment

The consumer or surrogate directed **EMPLOYER** is responsible for termination of employment, and for notifying the case manager and the payroll agent of all changes in the employment status of **EMPLOYEES**. The **EMPLOYER** must complete an "Employee Action Notice" form and submit to ARIS each time an **EMPLOYEE** terminates employment.

5. Instructions for Completing Timesheets

All timesheets shall be completed with the following information. **All items must be legible!**

- Print **EMPLOYEE** name and social security number on the top corner of timesheet.
- Print the waiver participants name under "consumer" at the top of the timesheet.
- Print the surrogate EMPLOYER'S name, if applicable, under "surrogate" at the top of the timesheet.
- Print the last day of the pay period under "Pay Period End Date". (refer to payroll schedule if needed)
- Enter the date worked in the "Date" column.

- Enter the daily work start time in the "In" column and work stop time in the "Out" column. **Note: If the employee lives with the waiver participant, they may write "Live-in" in place of "in" and "out" times.**
- Enter the total hours of Personal Care worked in decimal format (in 15-minute units) in the "Personal Care Hours" column for each day worked.
- Enter the total hours of Respite Care worked in decimal format (in 15-minute units) in the "Personal Care Hours" column for each day worked.
- Enter the total hours of Companion Care worked in decimal format (in 15-minute units) in the "Personal Care Hours" column for each day worked.
- Add the total Personal Care hours worked for week one and week two. Write the total hours in the "Personal Care Hours" box next to "Total Hours per Service for this Pay Period".
- Add the total Respite Care hours worked for week one and week two. Write the total hours in the "Respite Care Hours" box next to "Total Hours per Service for this Pay Period".
- Add the total Companion Care hours worked for week one and week two. Write the total hours in the "Companion Care Hours" box next to "Total Hours per Service for this Pay Period".
- The **EMPLOYEE** must sign and date at the bottom above "Employee Signature" and "Date".

- The **EMPLOYER** must sign and date the bottom above "Consumer/Surrogate Signature" and "Date".

Example of hours entered in decimal format:

one hour: 1.0
two hours: 2.0
two hours and 15 minutes: 2.25
three hours and 30 minutes: 3.5
three hours and 45 minutes: 3.75

6. Approved Service

The total number of hours for ***all employees combined*** must **not** exceed the authorized number of hours for any services as shown on the individual's approved Plan of Care.

7. Changes in Hours

The **EMPLOYER** should contact the case manager directly to review the need for changes in approved services. A written Service Plan change must be submitted and approved by DAIL **before** any increased service hours will be paid. **Approved changes will be effective the following payroll period after the request is received at DAIL, starting on a Sunday.**

8. Mailing Timesheets

Mail the timesheet to the payroll agent at the address at the bottom of the timesheet. The timesheet must be mailed to the payroll agent so that it reaches the payroll agent's office by Monday morning following the end of a pay period.

If more than one **EMPLOYEE** works for a waiver participant during the same pay period, the **EMPLOYER** must submit all employee timesheets for this pay period to the payroll agent at the same time.

9. Timesheet Errors

On occasion it may be necessary for ARIS to return timesheets to **EMPLOYERS**. This may result in employee's paychecks being delayed. ARIS is unable to process *any* timesheet that does not have the original signatures of both the **EMPLOYER** and the **EMPLOYEE**.

Timesheets will be returned to the employer when the following information is missing or incorrect:

1. Absence of employee name
2. Absence of consumer name

3. Absence of employee signature
4. Absence of employer signature
5. Signature of anyone other than the employer of record on the employer signature line.
6. Absence of dates of service.
7. Two consumers listed for services on one timesheet. Employees must fill out one time sheet per pay period for *each* consumer they provide care for.

Should a timesheet be returned to the **EMPLOYER** for one of the above reasons, the **EMPLOYER** must complete or correct the identified error, and re-submit the timesheet to ARIS. The timesheet will be processed and paid in the next pay period following receipt in the ARIS Office.

10. Other Reasons an Employee may not get Paid

Other reasons an **EMPLOYEE** may not get paid:

1. Late time sheets. Time sheets must be received in the ARIS office **no later than Monday** of each pay week, according to the Payroll Schedule.
2. Lack of, or incomplete Employer enrollment forms.
3. Lack of, or incomplete Employee enrollment forms.
4. Lack of patient share payment (when a patient share has been determined)
5. Lack of a Department of Aging and Independent Living (DAIL) authorized Service Plan

11. Pay Schedule

Paychecks will be generated by the payroll agent every two (2) weeks, according to the payroll schedule.

12. Pay Rate

As of **July 8, 2001** **EMPLOYEES** who are paid through Consumer or Surrogate Directed Services option will be paid:

- $10.00/hour Personal Care Services
- $8.50/hour for Respite Care Services
- $8.50/hour for Companion Services

Note: Workers are **not** paid overtime wages or benefits. The Medicaid rate identified on the Service Plan is higher than the **EMPLOYEE'S** wages because it includes worker's compensation and unemployment insurance that is covered by the state.

13. Patient Share

Under Long-Term Care Medicaid financial eligibility rules, some individuals must pay a monthly patient share payment to cover some of the costs of services. The amount of the patient share, if any, is determined by the Department for Children and Families (DCF). DCF will send a written notice to the individual explaining the amount (if any) of the required patient share. If the individual has a patient share, then:

- The patient share must be paid directly to ARIS each month in the amount indicated on the DCF notice of decision.
- The **EMPLOYER** must pay the monthly patient share in full with the timesheet of the first pay period of the month.
- Timesheets will not be processed, nor can payments to **EMPLOYEES** be made, unless the required patient share payment is submitted to the payroll agent.
- If the required patient share payment is not submitted to the payroll agent, the participant may be terminated from Consumer/Surrogate Directed Services.

Questions regarding Patient Share:
If there are questions about the **amount** of a patient share, contact the LTCM case manager or the local District Office of the Department for Children and Families (see Appendix A).

14. Unemployment Benefits

Every **EMPLOYEE** is eligible for unemployment benefits if work hours become unavailable or decrease. If you have questions about unemployment compensation coverage, or about submitting a claim, contact the payroll agent.

15. Workers' Compensation

Every **EMPLOYEE** is covered by workers' compensation insurance. If you have questions about workers' compensation coverage, or about submitting a claim, contact the payroll agent.

16. Taxes

Payments made to every **EMPLOYEE** are treated as earned income, and are taxed as earned income. The payroll agent processes payroll taxes, withholds taxes from wages and prepares annual W-2 tax withholding statements.

17. Problems with the Payroll Agent

EMPLOYERS and **EMPLOYEES** should first attempt to resolve payroll problems by directly contacting the payroll agent. If problems persist, the **EMPLOYER** or **EMPLOYEE** may contact the case manager for assistance. Finally, if problems are not satisfactorily resolved with the help of the case manager, contact DAIL at (802) 241-2400 or www.dad.state.vt.us.

18. Medicaid Fraud

Medicaid fraud is committed when an **EMPLOYER** or **EMPLOYEE** is untruthful regarding Long-Term Care Medicaid (LTCM) services provided, in order to obtain improper payment. The Medicaid Fraud and Residential Abuse Unit of the Vermont Attorney General's Office investigates and prosecutes people who commit fraud against the LTCM program. Medicaid fraud is a felony and conviction can lead to substantial penalties (including but not limited to, imprisonment up to ten years, or a fine up to $1,000 or an amount equal to twice the amount of the assistance or benefits wrongfully obtained, or both). Additionally, individuals convicted of Medicaid fraud will be excluded for a

minimum of five years from any employment with a program or facility receiving Medicaid funding.

Examples of Medicaid fraud include:

- Submitting timesheets for services not actually provided (e.g. signing or submitting a timesheet for services which were not actually provided)
- Submitting timesheets for services provided by a different person (e.g. signing or submitting a timesheet for services provided by a different person)
- Submitting twice for the same service (e.g. signing or submitting a timesheet for services which were reimbursed by another source, or signing or submitting a duplicate timesheet for reimbursement from the same source)

Suspected cases of fraud will be referred to the Attorney General's Medicaid Fraud Control Unit and may be referred to the local police authorities for further investigation and possible prosecution.

CHAPTER IX: Case Management Services

Case Management services are provided to all individuals receiving Long-Term Care Medicaid (LTCM) in the home-based setting. The case manager is responsible for certifying **EMPLOYERS** and monitoring the services and the health and welfare of individuals participating on the LTCM program.

1. Case Manager Responsibilities

The case manager must visit the individual on a regular basis, not less than once every 30 days.

Case managers are responsible for:

- Answering questions about the LTCM program
- Assisting individuals in gaining access to needed services
- Overseeing the assessment and reassessment of the individual
- Developing a service plan for the individual
- Monitoring the services included in an individual's service plan
- Assessing the adequacy of care being provided
- Evaluating the ability of a consumer or surrogate employer to manage services
- Reporting suspected cases of abuse, neglect, exploitation to Adult Protective Services (see Chapter X)
- Reporting suspected cases of Medicaid Fraud to the State (see Chapter VIII)

2. Case Manager Limitations

Case Managers are **not** responsible for:

- Completing or processing payroll forms,
- Payroll documentation and submission
- Hiring, firing and training employees

An individual's case manager can provide some ***advisory*** assistance with these activities, but the **EMPLOYER** is ultimately responsible for all employment issues concerning the **EMPLOYEES**.

CHAPTER X: Abuse, Neglect, and Exploitation

The State of Vermont requires, by law (Title 33, VT Statue), that all health professionals report cases of suspected adult abuse, neglect, and exploitation. Those who are "mandated" to report such cases include, but are not limited to:

- Long-Term Care Medicaid (LTCM) Case Managers,
- Personal Care Attendants,
- Respite Care Workers,
- Companion Workers,
- Home Health Agency Employees,
- Adult Day Employees,
- Hospital Employees,
- Social Workers,
- Physicians, and
- LTCM Payroll Agent (ARIS)

Other concerned individuals may also report suspected adult abuse, neglect, or exploitation**.** In most cases, the identity of the individual making the report shall remain confidential. **Reports are made by contacting the Vermont Department of Aging and Independent Living, Division of Licensing and Protection, Adult Protective Services (APS) at 1-800-564-1612.**

Attachment J – Waiting List Procedures and Scoring Too

Waiting List Procedures

Active Choices for Care (CFC) participants who meet the "High Needs" clinical criteria at reassessment will not be terminated from services as long as they continue to meet all other CFC eligibility criteria. *(See Section II. Eligibility)*

New Long-Term Care Medicaid (CFC) applicants who meet the "High Needs" clinical criteria may be placed on a waiting list if State funds are not available at the time of referral, using the following procedures:

1. If funds are not available at time of application, **Department of Disabilities, Aging and Independent Living (DAIL) staff** will complete a High Needs Wait List Score Sheet.

2. A score will be generated based on the individuals Activities of Daily Living (ADL), Cognition, Behavior, Medical Conditions/Treatments and Risk Factors.

3. **DAIL staff** will then place the individual on a waiting list in order of score.

4. **DAIL staff** will notify the individual in writing that they have been found clinically eligible for the High Needs Group and have been placed on a wait list. A case manager from the agency they chose on the application will be in contact with them. Appeal rights will also be included in the notice.

5. **DAIL staff** will forward a copy of the application and Wait List Score Sheet to the Case Management agency indicated on the application.

6. The **case manager** will contact individuals on the "High Needs" wait list on a monthly basis to monitor if they have had a change in their health or functional needs.

7. If the individual has had a significant health or functional status change the **case manager** will contact DAIL staff. **DAIL staff** shall reassess for clinical eligibility determination and/or rescore for wait list.

8. Applicants on a waiting list shall be admitted to the Choices for Care waiver as funds become available, according to procedures established by the Department and implemented by regional Choices for Care waiver teams. The Choices for Care **waiver teams** shall use professional judgment in managing admissions to the Choices for Care waiver, admitting individuals with the most pressing needs. The teams shall consider the following factors:

    xi. Unmet needs for ADL assistance;

xii. Unmet needs for IADL assistance;
xiii. Behavioral symptoms;
xiv. Cognitive functioning;
xv. Formal support services;
xvi. Informal supports;
xvii. Date of application;
xviii. Need for admission to or continued stay in a nursing facility;
xix. Other risk factors, including evidence of emergency need; and
xx. Priority score.

9. When funding is allocated to an individual, **DAIL staff** will notify the individual and continue the CFC application process.

10. **DAIL staff** will review the wait list with the Waiver Team at monthly meetings.

Vermont Department of Disabilities, Aging and Independent Living

Choices for Care – High Needs Wait List Score Sheet

Applicant Name:_____

Date:_____

Directions: This tool is to be used when there is a wait list for Choices for Care applicants who meet the High Needs Group clinical criteria. Utilizing the individual's clinical assessment and referral form, fill in the answers to the attached questions. Insert the score for each category into the table below. Add the column for a total score.

	Score
1. ADL's (score 0-8)	
2. Cognition (score 0-8)	
3. Behavior (score 0–9)	
4. Medical Conditions/Treatments (score 0-27)	
5. Risk Factors (score 0-20)	
Priority Score (0-72)**:**	

The team shall consider unmet needs for ADL and IADL assistance, behavioral symptoms, cognitive functioning, formal support services, informal supports, date of application, need for admission to a nursing facility, wait list score and other risk factors when determining who receives the available funding.

Comments/discussion:

DAIL Staff
Signature:_____

REGION:_____ Date Funding Allocated:_____

1. **Activity of Daily Living (ADL):** (non-late loss-from Clinical Assessment)
Check level of need for each activity and total all. From Clinical Assessment, page 1 & 2.

a. Toilet Use: ☐0- Independent ☐1- Supervision ☐2- Limited Assist

b. Eating: ☐0- Independent ☐1- Supervision ☐2- Limited Assist

c. Bed Mobility: ☐0- Independent ☐1- Supervision ☐2- Limited Assist

d. Transferring: ☐0- Independent ☐1- Supervision ☐2- Limited Assist

ADL Score: _____

2. **Cognition:** Select the **one** answer that best fits the applicant's current cognitive skills for daily decision-making. (From Clinical Assessment)

☐0 – Independent – decisions consistent/reasonable
☐4 – Modified independence – some difficulty in new situations only
☐8 – Moderately impaired – decision poor/cues/supervision required

Cognition Score: _____

3. **Behavior:** Score each behavior frequency and alterability then total all scores. (From Clinical Assessment) **Frequency:** Never= 0, Less than Daily=1, Daily=2 **Easily Altered:** Yes=0, No=1

Behavior	Frequency	Easily Altered?
a. Wandering		
b. Physically Abusive to others		
c. Resisting Care		
Totals:		

Behavior Score: _____ (frequency score + easily altered score)

4. **Medical Conditions/Treatments:** Check **all** conditions/treatments that require skilled nursing and total. (From Clinical Assessment)

☐3 – Severe Daily Pain Management
☐3 – End Stage Disease – less than daily
☐3 – Parenteral Feedings – less than daily
☐3 – Naso-gastric Tube Feeding – less than daily
☐3 – Wound Care – less than daily
☐3 – Medication Injections – less than daily
☐3 – Suctioning – less than daily
☐3 – Skilled Rehabilitation (PT/OT/ST)- daily
☐3 – Bladder or Bowel Retraining -daily

Medical Conditions/Treatments Score: _____

5. **Risk Factors:** Select **all** that apply and total all. From Eligibility Assessment page 3, E.

☐3 – Person has had multiple hospital admissions (3 or more) in last 6 months
☐3 – Person has had multiple Emergency Room visits (3 or more) in last 6 months.
☐3 – Person has fallen more than once in the last month. *Number of falls:*_____

☐3 – Person takes 5-7 prescription medications. *Number of medications:*_____
☐5 – Person takes 8 or more prescription medications. *Number of medications:*_____
☐3 – Primary caregiver is expressing burnout or is at risk of imminent harm, ill health, or loss of job
☐3 – Recent loss (past 3 months) of primary caregiver

☐3 – No informal caregivers

Risk Factors Score: _____ (combine all)

Attachment K: Scope of Services and Benefit Limitations

A. Services by Setting

Choices for Care (CFC) services include, by setting:

1. Home-Based Setting:
   a. Case Management
   b. Personal Care
   c. Adult Day
   d. Respite Care
   e. Companion
   f. Personal Emergency Response System
   g. Assistive Devices and Home Modifications
   h. Cash and Counseling *(under development)*

2. Enhanced Residential Care (ERC) Setting:
   ERC services are bundled into a daily rate to include:
   a. 24-Hour Supervision
   b. Nursing Overview
   c. Personal Care
   d. Medication Management
   e. Recreational Activities
   f. Laundry Services
   g. Housekeeping Services
   h. In Home Case Management

3. Nursing Facility (NF) Setting:
   Nursing facility services are bundled into a daily rate to include:
   a. Room and Board
   b. Skilled Nursing
   c. Personal Care
   d. Medication Management and pharmacy services
   e. Social Worker Services
   f. Recreation Activities
   g. 24-Hour On-Site Nursing Supervision
   h. Laundry Services
   i. Housekeeping Services
   j. Transportation
   k. Physical Therapy, Occupational Therapy and Speech Therapy
   l. Nutritional and Dietary Services
   m. Maintenance of Resident Clinical Records

4. Program for all Inclusive Care for the Elderly: *Under development*

NOTE: Refer to specific manual section for detailed service definitions and limitations.

B. Principles

1. CFC services foster respect, dignity, and a sense of well being for the individual being served.

2. CFC services respect individual rights, strengths, values, privacy, and preferences, encouraging individuals to direct and participate in their own plan of care and services to the fullest extent possible.

3. CFC services respect individual self-determination, including the opportunity for individuals to decide whether to participate in a program or activity.

4. CFC services are provided as part of a comprehensive and individualized plan of care, which is developed through collaboration to meet the needs of the individual. All CFC services are coordinated with other services.

5. CFC services are provided in an efficient manner, preventing duplication of services, unnecessary costs, and unnecessary administrative tasks. CFC services attempt to use resources efficiently to maximize the benefits and services available to all individuals.

6. CFC services will not be used to secure improper or inappropriate gain for the provider, provider staff, family members or any other person involved in the individual's care.

C. Desired Outcomes

1. The individual continues to reside in his/her setting of choice.

2. The individual's needs are met, and he or she is as healthy as possible.

3. The individual's optimal level of functioning and independence is achieved or maintained.

4. The individual is satisfied with services.

5. If applicable, primary caregivers receive relief from care giving responsibilities, as well as education and support, and continue to provide care.

6. If applicable, the individual's primary caregiver or family is satisfied with services.

7. Services are provided in an efficient manner, and duplication of effort and services is minimized.

Attachment L: MAP Procedures

Medicare Advocacy Project (MAP) Procedures

The purpose of the Medicare Advocacy Project procedures is to insure full utilization of Medicare nursing facility benefits.

1. New applicants, who require Choices for Care (CFC), VT Long-Term Care Medicaid as a payor source for nursing facility care, will be referred to the Department of Disabilities, Aging and Independent Living (DAIL).

2. **DAIL staff** determines clinical eligibility and completes the Clinical Certification form (CFC form 803) including hospital admission and payor source information.

3. **DAIL staff** sends a copy of the Clinical Certification form to the Department for Children and Families (DCF).

4. When an active CFC nursing facility resident has a change in status or setting the nursing facility provider submits a Change Report Form (LTC form 804) to DAIL staff, DCF and OVHA. Changes include:
    a. Re-admission from a three-day hospital stay, noting payor source
    b. Level of care change
    c. Discharge
    d. Death

5. DCF/Economic Services Division changes information on the LONG panel which is relayed to the EDS system.

6. OVHA tracks to see if Economic Services Division information matches LONG panel in ACCESS system. If changes need to be made, OVHA will make those changes to the EDS system.

7. OVHA will send the report to MAP in cases where an individual was admitted or readmitted to a nursing facility and who had a three-day hospital stay prior to the admission and who did not utilize the full 100 days of Medicare coverage.

8. MAP will verify with OVHA through ACCESS that the individual has Long-Term Care Medicaid coverage. MAP will follow up with a phone call to the nursing faciltiy provider to confirm or clarify the information, as necessary. They will look to determine how many days of Medicare were used in this spell of illness.

8. After MAP verifies individual in a nursing facility who has had a three-day hospital stay and did not receive the full 100 days of Medicare and is on Long-Term Care Medicaid, MAP sends a letter to the individual and his/her patient representative which asks that the individual sign an authorization for MAP to represent the person in a Medicare appeal. Once the signed form is received, the appeal process is started.

NOTE: ***Utilization review of Medicare covered services by the Home Health Agencies will be done on a retrospective basis quarterly by MAP.***

Attachment M

Employer/Agent Certification Form

Directions: This form is used to certify employers under the Choices for Care Consumer & Surrogate directed option and employers/agents under the Attendant Services Program**.** The employer/agent must meet **all** of the following standards to be eligible to direct services under the Choices for Care Home-Based setting or the Attendant Services Program. **IMPORTANT:** Surrogate employers or agents must live within close proximity to the individual in order to adequately monitor services and supervise employees.

Complete all questions for a new employer/agent. For annual reassessments with a previously certified employer/agent, only #5 is required. Obtain information directly from the prospective employer/agent. If needed, information may be obtained from other relevant sources. The assessor must clearly record responses and provide detailed examples as needed.

Status (check one): ☐ New Employer/Agent ☐ Re-certification of Employer/Agent

Program *(check one):* ☐ *Attendant Services Program*
☐ *Consumer Directed – Choices for Care*
☐ *Surrogate Directed – Choices for Care*

Individual Name*:* _____
Date*:*_____

Employer/Agent Name (if different that the individual)*:*
_____

Employer/Agent Relationship to Individual*:*
_____

Approximately how far does the surrogate/agent live from the individual? _____ miles

---

1. Communication and Decision Making: The employer/agent must be legally competent to make decisions, and must be able to effectively communicate verbally, in writing, or via assistive technology or other means.

a. Does the prospective employer/agent have a legal Guardian?……. o*Yes* o*No*
b. Does he/she have dementia, cognitive impairment, or mental retardation?…….. o*Yes* o*No c.*
d. Is he/she available on an on-going basis to act as the employer/agent……. oYes oNo

2. Knowledge of Disability and Related Conditions: *The employer/agent must have knowledge of the individual's disability and related conditions, and must be able to describe this knowledge to others. This may include use of written information, lists, devices, etc.*

a. Is the prospective employer able to describe the disability and related conditions?…….…… oYes oNo
b. Is he/she able to describe a plan to manage medications? …….....….. oYes oNo
c. Is he/she able to describe the use of assistive devices and/or adaptive equipment? ……. oYes oNo

3. Knowledge of Personal Assistance Needs: The employer/agent must have detailed knowledge of the personal assistance needs of the individual, including ADLs and IADLs, and the ability to identify safe and unsafe practices and/or situations.

a. Is the prospective employer able to describe a routine day and give examples of assistance needed?…… oYes oNo
b. Is he/she able to describe meal preparation and dietary needs?……. oYes oNo
c. Is he/she able to describe housekeeping needs? …….. oYes oNo
d. Is he/she able to identify current sources of paid and unpaid help? …….…….. oYes oNo

4. Ability to Manage Employees: The employer/agent must be able to direct recruitment, interviewing, hiring, scheduling, training, supervising, and termination of employees. This may include support or use of materials, such as the Home Share VT handbook, manuals, etc.
a. Is the prospective employer able to describe how to hire an employee? ……. oYes oNo
b. Is he/she able to describe how to train and supervise an employee? …….. oYes oNo
c. Is he/she able to describe what to do if the employee is sick or absent?……. oYes oNo

5. Ability to follow program requirements <u>once on the program</u>: At reassessment, the employer/agent must be able to understand and follow the requirements of participation in the program. This includes submitting all enrollment forms, submitting accurate timesheets as required by the payroll schedule. This may also include use of resources, such as a calendar, calculator, etc.

a. Is the employer/agent able to describe basic program procedures? ……. oYes oNo
b. Has he/she demonstrated the ability to track hours worked, calculate totals, and understand

pay periods?……. oYes oNo

c. Has he/she completed and submitted accurate timesheets?…….…… oYes oNo

d. Has he/she followed program rules and procedures? …….. oYes oNo

---

SUMMARY - **Assessor's summary of strengths and weaknesses identified above.**

-CERTIFICATION DECISION -

The prospective / current (circle one) employer/agent:

_____ ***does not*** *meet all standards to direct services at this time.*

_____ ***does*** *meet all standards to direct services with the understanding that this decision is contingent upon continued eligibility and compliance with employer qualifications and standards, and must be reviewed at least annually.*

_____ _____ _____

Assessor/Case Manager - print name *Assessor/Case Manager's signature* *Date*

_____ _____

Agency Name Phone #

Attachment N:Universal Provider Qualifications and Standards

A. Definition

A "provider" of services for the Choices for Care (CFC), Vermont Long-Term Care Medicaid program is defined as any entity that has been authorized by the Vermont Agency of Human Services, Department of Disabilities, Aging and Independent Living (DAIL) to provide, and be reimbursed by the State for CFC services as outlined in this manual.

B. Provider Qualifications

All Choices for Care (CFC) providers must:

1. Be authorized by the Vermont Department of Disabilities, Aging and Independent Living (DAIL) to provide CFC services; and

2. Demonstrate compliance with provider standards, including applicable Federal and State regulations; and

3. Maintain an up-to-date Provider Agreement with DAIL, if applicable; and

4. Be enrolled with Electronic Data Systems (EDS) as a Vermont Medicaid provider.

C. Provider Standards

All Choices for Care (CFC) provider agencies shall:

1. Comply with all applicable provider qualifications and provider standards.

2. Provide applicable services according to service principles, definitions, standards, approved activities, and limitations.

3. Provide services in a cost-effective and efficient manner, preventing duplication of services, unnecessary costs, and unnecessary administrative tasks.

4. Ensure that all staff with direct participant contact have passed the Adult Protective Services (APS) screening for substantiated histories of abuse, neglect, or exploitation.

5. Ensure that all staff with direct participant contact have passed the Social and Rehabilitative Services (SRS) screening for substantiated histories of abuse, neglect, or exploitation.

6. Implement structured internal complaint and appeals procedures.

7. Fully inform individuals of their rights and responsibilities in working with the agency, including both internal and formal waiver complaint and appeal procedures.
8. Encourage and assist the participant to direct as much of her/his own care as possible.

9. Implement policies and procedures that will be used to supervise and/or monitor services.

10. Follow Vermont statute 33 V.S.A. § 6903 regarding mandated reporting of abuse, neglect, and exploitation.

11. Maintain all financial records in accordance with Generally Accepted Accounting Principles (GAAP) for period of seven (7) years.

12. Maintain all records pertaining to delivery and documentation of CFC services for a minimum of three (3) years.

13. Demonstrate to the DAIL that they have sufficient expertise and capacity to meet the needs of the target population, including effective working relationships with other local or regional providers and agencies.

14. Ensure services are provided as defined in the approved CFC Service Plan.

15. Ensure that staff have the skills and/or training required to meet the needs of the participant.

16. Maintain accurate and complete documentation of services provided to the individual.

17. Report any concerns about services or the individual's status and condition to the individual’s case manager, if the individual is in the home-based or ERC setting.

18. Ensure that the volume of services and rate charged to the State are based on services actually provided to the participant, within the limits specified in the approved Service Plan. (*See Enrollment & Billing Procedures*)

19. Avoid conflicts of interest between the interests of the individual and the interests of the provider and its staff.

20. Assist the State in ensuring that services are provided in compliance with the standards, policies and procedures established by the State. This includes participating in structured evaluation activities developed by the State.

21. Abide by principles of confidentiality and all applicable confidentiality policies and laws.

22. Comply with all applicable laws and regulations regarding employment, including the provision of workers compensation insurance and unemployment insurance to employees.

Attachment P - Denial Notice

CHOICES FOR CARE NOTICE OF DENIAL

Dear:

The Division of Disability and Aging Services has reviewed your application for the Choices for Care program. Based on the information provided, you do not currently meet the clinical criteria for eligibility. **Therefore your application for the Choices for Care program is denied.**

If you do not agree with this decision, you or your legal representative may appeal the denial in writing or by phone. You may appeal to the Department Commissioner within 30 days of receipt of this notice by calling (802) 241-2400 or writing:

Commissioner's Office
Department of Disabilities, Aging and Independent Living
103 South Main Street
Waterbury, VT 05671-2301

You may also appeal to the Human Services Board, either instead of appealing to the Department Commissioner or in addition to the Commissioner's review. An appeal to the Human Services Board must be submitted within 90 days of receiving this notice, or the written decision of the Commissioner, by writing:

Human Services Board
120 State Street
Montpelier, VT 05620-4301

To determine whether you are eligible for Legal Aid assistance, call Vermont Legal Aid at 1-800-889-2047.

Please call me if you have any questions or your circumstances change.

Sincerely,

Long-Term Care Clinical Coordinator

I. Appeals

An individual may request a Commissioner's hearing, a fair hearing before the Human Services Board, or both. An appeal may be made to the Commissioner and the Human Services Board at the same time. An appeal may also be made to the Human Services Board following a Commissioner's hearing.

A. Commissioner's Hearing

1. An **applicant or participant, or his or her legal representative**, who wishes to appeal a decision regarding clinical eligibility, financial eligibility or termination of eligibility may request a formal review of that decision by the Commissioner of the Department.

2. The request for a Commissioner's hearing may be made orally or in writing, and shall be made within thirty (30) days of receiving written notice.

3. A request for a Commissioner's hearing shall be made by calling or writing to:

   Commissioner's Office
   Department of Disabilities, Aging & Independent Living
   103 South Main Street
   Waterbury, VT 05671
   802-241-2401

4. The **Commissioner** shall send written notice of the decision, with appeal rights, to the applicant or participant within thirty (30) days of the completion of the hearing.

B. Fair Hearing

An **applicant or participant, or his or her legal representative**, may file a request for a fair hearing with the Human Services Board. An opportunity for a fair hearing will be granted to any individual requesting a hearing because his or her claim for assistance, benefits or services is denied, or is not acted upon with reasonable promptness; or because the individual is aggrieved by any other Department action affecting his or her receipt of assistance, benefits or services; or because the individual is aggrieved by Department policy as it affects his or her situation. The Department shall respond to any clear indication (oral or written) that an applicant or participant wishes to appeal by helping that person to submit a request for a hearing.

1. **An applicant or participant, or his or her legal representative**, who wishes to appeal a decision of the Commissioner or any decision regarding clinical eligibility, financial eligibility or termination of eligibility, may request a fair hearing with the Human Services Board.

2. The request for a fair hearing must be made within ninety (90) days of receiving the written notice of determination or the written notice of the decision of the Commissioner.

3. A request for a fair hearing shall be made to:

   Human Services Board
   120 State Street
   Montpelier, VT 05620-4301
   802-828-2536

C. Continuation of Services Pending Appeal

1. Moderate Needs services shall not be provided to new applicants during the appeals process.

2. Moderate Needs services may continue to be provided to enrolled participants during the appeals process.

3. In order to continue to receive services, enrolled participants must request continued services when submitting the appeal. Choices for Care services shall be discontinued on the effective date of the decision unless the appeal is requested as of the effective date of the decision. In no event shall the effective date occur on a weekend or holiday.

4. Continuation of services does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require advance notice.

D. Adverse Action

When a **DAIL** decision will end the services an individual has been receiving, the notice of decision shall be mailed at least eleven (11) days before the decision will take effect, except when:

1. **DAIL** has facts confirming the death of the individual;

2. **DAIL** has facts confirming that the individual has moved to another state;

3. **DAIL** has facts confirming that the individual has been granted Medicaid in another State;

4. The individual has been admitted to a facility or program that renders the individual ineligible for services;

5. The Department receives a statement signed by an individual that states that he or she no longer wishes services; or

6. The individual's whereabouts are unknown and the post office returns agency mail directed to him or her indicating no forwarding address.

Attachment S: Case and Counseling timeline

Category	Product	Due Date	Time Needed
Meets with counselor	Expectations for counselors	August 1, 2005	30
Quality monitoring	Outcome measures	September 1, 2005	60
Quality monitoring	Interaction with broader QA&I process	September 1, 2005	60
Contacts ISO	Front money to ISO if retrospective billing	October 1, 2005	90
Learns of Program	Advisory group developed	August 1, 2005	21
Meets with counselor	RFP if needed	August 15, 2005	30
Monitoring	Responsibilities for monitoring	August 15, 2005	30
Has problems or questions	Expectations for unscheduled counselor/consumer contacts	August 15, 2005	21
Has problems or questions	Expectations counselor availability	August 15, 2005	14
Monitoring	Monitoring schedule	August 15, 2005	14
Contacts ISO	ARIS v. RFP	September 1, 2005	30
Contacts ISO	Clarify expectations of ISO/Counselor/ Consumers	September 1, 2005	30
Quality monitoring	Reporting to CMS/RWJ	September 1, 2005	30
Cash value determined	Monitoring value of new vs. existing assessments	October 1, 2005	60
Reassessment	Content of and responsibility for reassessments	October 1, 2005	60
Meets with counselor	Identify provider(s) of counseling services	November 1, 2005	90
Needs assessment	Initial assessment process developed (ILA v. first assessment by nurses)	October 1, 2005	30
Contacts ISO	EDS C&C codes	November 1, 2005	90
Contacts ISO	Dispensing cash	November 1, 2005	60
Contacts ISO	Safeguards against double billing	December 1, 2005	90
Contacts ISO	Auditing structures	December 1, 2005	90
Acute hospital or NH stay	Cross checking institutional bills against C&C submissions	December 1, 2005	90
Learns of Program	Meetings with VAST	October 15, 2005	30
Cash value determined	Value of program elements	October 15, 2005	30
Contacts ISO	Employer guidelines for benefits	October 15, 2005	30
Monitoring	Routine reporting to DAIL	October 15, 2005	30
Meets with counselor	Counselor training developed; includes content on abuse etc.	November 15, 2005	60
Reassessment	Routine reassessment schedule	October 1, 2005	14
Quality monitoring	Consumer surveys?	October 1, 2005	14
Quality monitoring	Quality monitoring visits to ISO counseling agency	October 15, 2005	15
Chooses C&C	Self screening tool developed	November 1, 2005	30
Cash value determined	Discount rate	November 1, 2005	60
Meets with counselor	Contact timelines	November 1, 2005	30
Meets with counselor	PoC guidelines	November 1, 2005	30
Meets with counselor	Cash guidelines	November 1, 2005	30
Meets with counselor	Employer knowledge/training expectations	November 1, 2005	30

Contacts ISO	Purchasing goods	November 1, 2005	30
Contacts ISO	ISO reimbursement	November 1, 2005	30
Implements plan	Cash monitoring	November 1, 2005	30
Reassessment	Non-routine reassessments	November 1, 2005	30
Meets with counselor	Counselor reimbursement for initial PoC	November 15, 2005	30
Disenrollments	Appeal processes	December 15, 2005	60
Disenrollments	Involuntary disenrollment for failure to meet LoC	December 15, 2005	60
Disenrollments	Involuntary disenrollment for health/safety or fraud	December 15, 2005	60
Implements plan	Vouchers v. reimbursement for goods purchases	November 1, 2005	14
Meets with counselor	PoC/budget approval incl defining who approves and process	November 15, 2005	21
Meets with counselor	Surrogate authorization process/documentation	November 15, 2005	14
Has problems or questions	On-going counselor reimbursement	November 15, 2005	21
Chooses C&C	Consumer v. surrogate process	November 15, 2005	14
Contacts ISO	PoC to ISO process	November 15, 2005	14
Acute hospital or NH stay	Post-acute or post-NH requirements	November 15, 2005	14
Quality monitoring	Role of ombudsman	November 15, 2005	14
Chooses C&C	Rules for who is a surrogate developed	December 1, 2005	30
Chooses C&C	Consent and choice document – includes information about responsibilities	December 1, 2005	30
Contacts ISO	Consents developed for PoA and other authority to ISO	December 1, 2005	30
Learns of Program	Regional meetings	December 15, 2005	45
Chooses C&C	Training to CMs	December 15, 2005	45
Meets with counselor	Consumer handbook	December 15, 2005	75
Implements plan	Worker safety training?	December 15, 2005	45
Disenrollments	Notification to consumer	December 15, 2005	45
Learns of Program	General publicity?	January 1, 2006	60
Meets with counselor	Counselor/consumer documentation	December 1, 2005	21
Meets with counselor	Budget/plan documentation	December 1, 2005	21
Implements plan	Criminal background check expectations	December 1, 2005	21
Learns of Program	Decide who signs letter	December 1, 2005	15
Needs assessment	Training of assessors	December 15, 2005	30

Meets with counselor	Training implemented	December 15, 2005	30
Acute hospital or NH stay	Notification requirements and processes	December 15, 2005	30
Disenrollments	Notification to ISO and counselor	December 15, 2005	30
Meets with counselor	Develop special connections with APS?	January 1, 2006	45
Implements plan	"Mandatory" worker training?	January 1, 2006	45
Learns of Program	C&C component of nurse training	December 1, 2005	14
Chooses C&C	Next steps	December 1, 2005	14
Chooses C&C	C&C component to nurse training	December 1, 2005	14
Learns of Program	Written communication to providers	December 1, 2005	7
Contacts ISO	Timesheet process	December 1, 2005	7
Learns of Program	Letter to current waiver participants	December 15, 2005	21
Quality monitoring	Monitoring complaints	January 1, 2006	30
Implements plan	On-going employer training content?	January 15, 2006	45
Monitoring	Monitoring protocols	January 15, 2006	45
Implements plan	On-going worker training curriculum	February 1, 2006	60
Learns of Program	Flyer for all new waiver participants	January 1, 2006	21
Has problems or questions	On-going counselor supervision and training	January 1, 2006	21
Disenrollments	Continuity of care expectations	January 1, 2006	21
Disenrollments	Re-enrolling disenrolled consumers	January 15, 2006	30
Quality monitoring	Receiving and responding to complaints	January 1, 2006	14
Quality monitoring	Monitoring a/n/e allegations	January 1, 2006	14
Cash value determined	Working towards "case rates"	February 1, 2006	30
Learns of Program	Develop C&C Newsletter?	February 15, 2006	45
Implements plan	Role of peer support	March 1, 2006	60
Implements plan	Peer support process	May 1, 2006	60
Has problems or questions	Policy for Unannounced visits by counselor?	January 1, 2006	45
Learns of Program			
Chooses C&C			
Needs assessment			
Cash value determined			
Meets with counselor			
Contacts ISO			
Implements plan			

Has problems or questions			
Acute hospital or NH stay			
Monitoring			
Reassessment			
Disenrollments			
Quality monitoring			

Attachment T- Emergency Back-up

Vermont Department of Aging and Independent Living, Long-Term Care Medicaid

Back-up Care and Emergency Plan

This plan must be reviewed at least annually. A copy must be maintained in the individual's home in a conspicuous place.

Date created: _____

Back-up personal care

In the event that the primary personal care attendant does not show up for work, or is otherwise unavailable, indicate at least one back-up person or agency to contact:

1. Name: _____
Relationship to individual: _____
Phone numbers: _____/home _____/work

2. Name: _____
Relationship to individual: _____
Phone numbers: _____/home _____/work

3. Name: _____
Relationship to individual: _____
Phone numbers: _____/home _____/work

If none, indicate reason:

Emergency Contacts

1. In the event of a medical emergency or fire, **call 911**.

2. Personal Emergency Response Systems (PERS): Individuals enrolled with a PERS provider may push the PERS button in any emergency.

3. Emergency family/friend contact:_____
Relationship to individual: _____
Phone numbers: _____/home _____/work

4. Home Health Agency: _____
Normal hours of operation: _____ phone number: _____
After-hours on-call phone number: _____

5. Case Management Agency:_____
Normal hours of operation: _____ phone number: _____
After-hours on-call phone number: _____

6. Primary Doctor:_____
Normal hours of operation: _____ phone number: _____
After-hours on-call phone number: _____

Attachment U- Interpreter policy

AGENCY OF HUMAN SERVICES

POLICY OUTLINE

LIMITED ENGLISH PROFICIENCY

September 1, 2003

I: GOAL

It is the policy of the State of Vermont, Agency of Human Services that all departments and programs will provide language assistance as may be needed to ensure meaningful access to our programs. Each department will take steps to provide assistance so that persons seeking services may communicate effectively with program providers and with agency and department staff.

Departments must take steps to ensure persons seeking services are able to understand which services and benefits are available to them, and how they may best receive them. This includes access to timely assistance for access to emergency services.

II: AUTHORITY

As an agency receiving federal funds, all departments and programs are governed by Federal Executive Order # 13166 signed in August of 2000. (Attached) This Order established a goal to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency. This order required that federal agencies adopt plans to ensure that persons limited in English proficiency "can meaningfully access programs and activities".

Most of the programs within the Agency of Human Services are governed by Health and Human Services, which issued guidelines found at Federal Register Vol. 657, No. 22 / Friday February 1, 2002., regarding implementation of services to persons with limited English proficiency. In addition, regulations governing non-discrimination can be found at CFR Title 45, Part 80. Other federal departments such as Agriculture and the Department of Justice have their own specific guidelines or regulations.

III: INTERPRETIVE AND TRANSLATION SERVICES

The Agency maintains three forms of interpretive and translation services to assist its staff in providing services to persons whose native language is not English, and whose proficiency in English is limited. Those Services are:

A. Oral Interpretive Services: The Agency maintains a contract to provide oral interpretive services throughout the state.

B. Written Translation Services: The Agency maintains a contract to provide translation of documents, brochures, application forms and any other needed written materials.

C. Telephonic Services: The State, through the Department of Buildings and General Services, maintains a contract for assistance to allow all state agencies and departments to access interpretive and translation services telephonically.

Attached to this policy are a list of contracted resources and their contact information.

IV: RESPONSIBILITIES

A. Central Office's Responsibility

1. The agency's central office will maintain overall coordination of this policy.

2. The agency's central office will coordinate and disseminate information. Each department will have one or more representatives to serve on an agency language assistance committee, which meets at least semi-annually.

3. The agency's central office will maintain the contracts for interpretive and translation services for use by all departments.

4. The Agency will continue to work with the community, including service providers, to maximize resources and expand language assistance.

5. The Agency will make efforts to identify secondary resources, other than those services for which we have contracts, and identify how they can be timely accessed.

6. The Agency will attempt to include in its contracts for interpretive and translation services that whenever possible, the contractor or grantee will allow community based organizations serving the same population in concert with the Agency to have access the state's contract rates and the lowest rate possible.

7. The Agency will develop a consistent practice to be applied to electronic correspondence, applications, and web sites.

B. Department Responsibilities

The following departments are included in this policy: Aging & Disabilities; Corrections; Developmental and Mental Health Services; Health; Prevention, Assistance, Transition, and Health Access; Social & Rehabilitation Services. Departments shall also include The Office of Child Support; The State Office of Economic Opportunity the Agency's Central Office, The Agency's Planning Division, and the Developmental Disabilities Council.

1. Each department will designate a person who is responsible for coordination of language assistance for that department.

2. Each department will inform contractors, grantees, and sub-grantees receiving federal funds, of their requirements to ensure that persons with limited English proficiency will have meaningful access to services provided by them. Organizations receiving support from the agency or its departments will be required to provide such assurances as a condition of contract and grant that these requirements are met. If necessary, organizations should include this item in their budget when submitting requests for grants and contracts.

3. Each department will develop a program for staff awareness or training outlining how the department provides for language assistance. The department (or agency) employee orientation package will also contain reference to this policy with guidance for new employees.

4. Each department will develop a program to ensure that supervisors and managers are aware of the resources that exist to assist persons with limited English proficiency.

5. Each department will modify casework methods to ensure that record keeping includes the ability to notify staff that a client may need language assistance with oral or written casework materials.

6. Each department will develop and implement a procedure for notifying clients of their rights to complain about meaningful access to services.

7. To avoid duplication, each department will maintain a centralized record of applications, forms, and announcements that are translated into languages other than English, that can be available to all of their district offices and where applicable to other departments.

C. Shared Responsibilities - Agency and Department

1. On a periodic basis, assessments will identify languages likely to be spoken by persons needing assistance, and to determine the extent of language assistance services that may be required.

2. The agency and departments will develop a program to inform staff on how to best serve persons who need language assistance. This should included reference to this policy in new employee orientation, and references in on going training and orientation programs.

3. The agency and all departments will prominently display and maintain uniform signs in all lobbies or entrances to Human Services Offices, which tell clients (in languages frequently encountered) of their ability to seek and receive language assistance at no cost to the client.

4. The agency and departments will use uniform language identification cards to be used as a regular part of client intake.

5. The agency and departments will maintain a uniform procedure for timely and effective telephone communication between staff and clients who have limited English proficiency.

6. Periodic assessment of public service announcements and public notices will begin to evaluate the need for notices and announcements to be done in language other than English.

V. IMPLEMENTATION

The overall responsibility for providing meaningful access to services to those with limited English proficiency rests primarily with the departments and their programs. To ensure a consistent and more comprehensive approach, the Agency's Division of Administrative Services, Office of the State Refugee Coordinator, shall oversee the implementation of this policy as a means of combining resources and shall maintain the committee on limited English proficiency as a mechanism to review its implementation.