CHAPTER 501-COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR AGED AND DISABLED WAIVER SERVICES

Replace	Title	Change Date	Effective Date
501.2.1	CIB Policy and Restrictions	11-26-2007	01-01-2008
501.7.1.4	Assessments	11-26-2007	01-01-2008
501.7.4	Monthly RN Services	11-26-2007	01-01-2008
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501.2	Provider Enrollment and Certification Requirements, Management of Incidents, and Agency Closure	04-02-07	05-01-07
501.2.1	Provider Guidelines and Responsibilities for Management of Incidents	04-02-07	05-01-07
501.2.2	Allegations of Abuse or Neglect	04-02-07	05-01-07
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501.2.2.2	Simple Incidents	04-02-07	05-01-07
501.2.2.3	Documentation and Investigation Procedures	04-02-07	05-01-07
501.2.2.4	Documentation and Investigation Procedures	04-02-07	05-01-07
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501.2.3.1	Agency Closure – Case Management Agency	04-02-07	05-01-07
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501.2.3.3	Agency Closure – Administrative (Involuntary) Closure	04-02-07	05-01-07
501.3	Member Eligibility and Enrollment Process	04-02-07	05-01-07
501.3.1	Member Eligibility	04-02-07	05-01-07

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501.3.3.2	Results of Initial Medical Evaluation	04-02-07	05-01-07
501.3.4	Medical Reevaluation	04-02-07	05-01-07
501.3.4.1	Results of Medical Reevaluation	04-02-07	05-01-07
501.3.5	Periodic Medical Reevaluation	04-02-07	05-01-07
501.3.6	Financial Eligibility	04-02-07	05-01-07
501.4.1	Member Responsibilities	04-02-07	05-01-07
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November 26, 2007

Section 501.2.1 CIB Policy and Restrictions

Introduction: CIB Policy and Restrictions.

Old Policy: Did not specify that the criminal investigation background check (CIB) must be at a minimum a state wide. Did not specify felony to domestic battery or domestic assault

New Policy: Added a minimum requirement that CIBs must be conducted state wide; also added specification of felony to domestic battery or domestic assault

Change: addition of statewide component to CIBs; added felony to domestic battery or domestic assault

Directions: Replace Section 501.2.1.

Section 501.7.1.4 Assessments

Introduction: Section 501.7.1.4. Assessments

Old Policy: Assessments did not include assessment for emergency back-up

New Policy: Added requirement that assessment be conducted for emergency back-up

Change: added emergency back-up component

Directions: Replace Section 501.7.1.4.

Section 501.7.4 Monthly RN Services

Introduction: Section 501.7.4. Monthly RN Services

Old Policy: For additional hours being requested did not require that documents containing a change in condition must be on hospital or physician letterhead.

New Policy: Added requirement that documents containing information about a change in condition must be on hospital or physician letterhead. A check list from a provider entity signed by a physician will not suffice.

Change: Information about a change in condition must be on either hospital or physician letterhead.

Directions: Replace Section 501.7.4

CHAPTER 501-COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR AGED AND DISABLED WAIVER SERVICES

April 02, 2007

Table of Contents

Introduction: Table of Contents for Chapter 500.

Old Policy: Did not include the Personal Options Component

New Policy: Personal Options added

Change: Table of Contents includes Personal Options

Directions: Replace Table of Contents

Section 501.1 Program Description

Introduction: Section 501.1 Program Description
Old Policy: Did not include Personal Options
New Policy: Personal Options added
Change: Personal Options Description added to program description
Directions: Replace section 501.1

Section 501.2 Provider Enrollment and Certification Requirements, Management of Incidents, and Agency Closure

Introduction: Section 501.2, Provider Enrollment and Certification Requirements, Management of Incidents, and Agency Closure
Old Policy: Did not include Personal Options.
New Policy: Personal Options added
Change: Language regarding Personal Options F/EA-RC, enrollment and management of incidents added.
Directions: Replace section 501.2

Chapter 501.2.1 CIB Policy and Restrictions

Introduction: This section lists restrictions for employment with regards to the result of the CIB.
Old Policy: Did not include restrictions
New Policy: Lists criminal offenses that would exclude an individual from providing ADW services
Change: The individual shall not be approved, employed or considered for employment if ever convicted of: . . . . .
Direction: Add this section

CHAPTER 501-COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR AGED AND DISABLED WAIVER SERVICES

Chapter 501.2.2 Provider Guidelines and Responsibilities for Management of Incidents

Introduction: This section introduces providers' guidelines for management of incidents.
Old Policy: Did not include Personal Options
New Policy: Personal Options added
Change: Personal Options providers are mandatory reporters. Personal Options providers must report any incidents to the F/EA-RC.
Direction: Replace this section

Chapter 501.2.3 Allegations of Abuse or Neglect

Introduction: This section defines abuse and neglect and mandatory reporting requirements
Old Policy: Did not include Personal Options
New Policy: Personal Options added
Change: All mandatory reporting requirements applies to Personal Options
Directions: Replace this section

Chapter 501.2.2.1 Critical Incidents

Introduction: This section describes Critical Incidents
Old Policy: Did not include Personal Options
New Policy: Personal Options added
Change: All critical incident information applies to Personal Options
Directions: Replace this section

Chapter 501.2.2.2 Simple Incidents

Introduction: This section describes Simple Incidents
Old Policy: Did not include Personal Options
New Policy: Personal Options added
Change: All simple incident information applies to Personal Options
Directions: Replace this section

Chapter 501.2.2.3 Documentation and Investigation Procedures

Introduction: This section describes the documentation and investigation requirements for Incidents
Old Policy: Did not include Personal Options
New Policy: Personal Options added.
Change: Personal Options incident reports will be made to the F/EA and the F/EA will maintain a file
Directions: Replace this section

CHAPTER 501-COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR AGED AND DISABLED WAIVER SERVICES

Chapter 501.2.2.4 Documentation and Investigation Procedures

Introduction: This section describes the documentation and investigation requirements for Incidents
Old Policy: Did not distinguish who was the reporting agency in the monthly reports for member hospitalization.
New Policy: Designates that the homemaker agency as the reporting agency
Change: Member hospitalizations should only be reported by the HMA on the Monthly Incident Tracking Report.
Directions: Replace this section

Chapter 501.2.2.4 Documentation and Investigation Procedures

Introduction: This section describes the documentation and investigation requirements for Incidents
Old Policy: Did not include Personal Options
New Policy: Personal Options added.
Change: Personal Options incident reports will be made to the F/EA and the F/EA will maintain a file
Directions: Replace this section

Chapter 501.2.3 Agency Closure

Introduction: This section describes the process for agency closure.
Old Policy: Did not include Personal Options
New Policy: Personal Options added
Change: A personal options provider and/or member must notify the F/EA when a worker terminated participation as a Personal Options provider.
Directions: Replace this section

Chapter 501.2.3.1 Agency Closure- Case Management Agency

Introduction: This section describes the process for case management agency closure.
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: Not applicable to Personal Options
Directions: Replace this section

Chapter 501.2.3.2 Agency Closure- Homemaker Agency

Introduction: This section describes the process for homemaker agency closure.
Old Policy: Did not refer to Personal Options

CHAPTER 501-COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR AGED AND DISABLED WAIVER SERVICES

New Policy: Personal Options reference added
Change: Not applicable to Personal Options
Directions: Replace this section

Chapter 501.2.3.3 Agency Closure - Administrative (Involuntary) Closure

Introduction: This section describes the process for administrative closure.
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: All of the above information also applies to Personal options
Directions: Replace this section

Chapter 501.3 Member Eligibility and Enrollment Process

Introduction: This section describes the member eligibility and enrollment process.
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: Member eligibility and enrollment process information also applies to Personal Options.
Directions: Replace this section

Chapter 501.3.1 Member Eligibility

Introduction: This section states that the QIO under contract with BMS determines medical eligibility
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: All of the above medical eligibility information also applies to Personal Options.
Directions: Replace this section

Chapter 501.3.1 .1 Purpose

Introduction: This section states the purpose of medical eligibility
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: All of the above purpose information also applies to Personal Options.
Directions: Replace this section

Chapter 501.3.2 Member Criteria

Introduction: This section states that the medical criteria requirements for the program
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added

Change: All of the above medical criteria information also applies to Personal Options.
Directions: Replace this section

Chapter 501.3.2.1 Levels of Care Criteria

Introduction: This section states that the level of care criteria for the program
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: All of the above level of care criteria information also applies to Personal Options.
Directions: Replace this section

Chapter 501.3.2.2 Levels of Care Service Limits

Introduction: This section states that the level of care criteria for the program
Old Policy: Did not refer to Personal Options
New Policy: Personal Options monthly budget added
Change: Personal Options monthly budget added to correspond with level of care
Directions: Replace this section

Chapter 501.3.3 Eligibility Process

Introduction: This section states that an individual must meet both medical and financial eligibility
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: All of the above level of eligibility process also applies to Personal Options.
Directions: Replace this section

Chapter 501.3.3.1 Initial Medical Evaluation

Introduction: This section states the process for the initial medical evaluation
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: All of the above initial medical evaluation process also applies to Personal Options.
Directions: Replace this section

Chapter 501.3.3.2 Results of Initial Medical Evaluation

Introduction: This section states the approval and denial process for the initial medical evaluation
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added

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Change: If personal options is selected the QIO will notify the Bureau of Senior Services. All of the above initial medical evaluation denial process also applies to Personal Options.
Directions: Replace this section

Chapter 501.3.4 Medical Reevaluation

Introduction: This section states the medical reevaluation process
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: All of the above information on medical reevaluation also applies to Personal Options
Directions: Replace this section

Chapter 501.3.4.1 Results of Medical Reevaluation

Introduction: This section states the approval and denial process for the medical reevaluation
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: Results of approved or denied medical reevaluation are sent to the Personal Options Fiscal /Employer Agent if applicable.
Directions: Replace this section

Chapter 501.3.5 Periodic Medical Reevaluation

Introduction: This section states the periodic medical reevaluation process
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: All of the above information on periodic medical reevaluation also applies to Personal Options
Directions: Replace this section

Chapter 501.3.6 Financial Eligibility

Introduction: This section states the financial eligibility process
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: The personal options member is responsible for ensuring that a financial application is made at the county DHHR office.
Directions: Replace this section

Chapter 501.4.1 Member Responsibilities

Introduction: This section states the responsibilities of the ADW member

Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: Personal options transfer option added; documentation requirement on the personal options timesheet.
Directions: Replace this section

Chapter 501.4.2 Transfer to Different Agency

Introduction: This section states the process for transfer to a different provider agency
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: Added policy on Personal Options transfer policy from and to the traditional agency model
Directions: Replace this section

Chapter 501.4.3 Emergency Transfers

Introduction: This section states the process for emergency transfer
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: Personal Options member or representative must submit supporting documentation that explains why the member is in emergency status.
Directions: Replace this section

Chapter 501.4.4 Discontinuation of Services

Introduction: This section states the policy for discontinuation of services
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: For personal options the F/EA notifies BOSS in writing the reasons for discontinuation of services and the steps taken.
Directions: Replace this section

Chapter 501.5 Member Grievance Process

Introduction: This section states the grievance policy
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: Personal options grievance form and process added
Directions: Replace this section

Chapter 501.6 Member Services and Supports

CHAPTER 501-COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR AGED AND DISABLED WAIVER SERVICES

Introduction: This section states the services available to Personal Options members
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: Personal Options Participant-Directed Goods and Services added
Directions: Replace this section

Chapter 501.6.1 Informal Supports

Introduction: This section describes informal supports
Old Policy: Did not refer to Personal Options
New Policy: Personal Options reference added
Change: The above information on informal supports also applies to Personal Options
Directions: Replace this section

Chapter 501.7.3.2 Homemaker – Staff Qualification and Training

Introduction: This section states the required documentation of staff qualification and training
Old Policy: Did not refer to Personal Options
New Policy: Personal Options section added
Change: Documentation of required training and licenses for Personal Options must be kept on file by the F/EA.
Directions: Replace this section

Chapter 501.7.7 Functions or Tasks not to be Performed by the Homemaker

Introduction: This section describes the functions and tasks not to be performed by homemakers.
Old Policy: Did not refer to Personal Options
New Policy: Personal Options added
Change: The resource consultant is to be notified if at anytime a HM is witnessed to suspect of performing any prohibited tasks by any staff.
Directions: Replace this section

Chapter 501.7.8 Homemaker Basic Training Requirements

Introduction: This section describes the training required non-licensed staff for direct care.
Old Policy: Did not refer to Confidentiality Laws and Regulations
New Policy: Added Confidentiality Laws and Regulations
Change: Confidentiality Laws and Regulations (HIPPA)
Directions: Replace this section

Chapter 501.7.10 Medical Adult Day Care

Introduction: This section defines Medical Adult Day Care services

Old Policy: Did not refer to Personal Options
New Policy: Personal Options added
Change: **M**embers who choose personal options can not self-direct MADC but may purchase these services from an agency.
Directions: Add this section

Chapter 501.7.11 Personal Options Code, Unit, Limit and Documentation Requirements

Introduction: This section defines Services, Code, Limit and Documentation Requirements
Old Policy: Did not refer to Personal Options
New Policy: Personal Options section added
Change: Provider may bill the encounter code for the appropriate level of care, which is all inclusive of Case Management, Homemaker RN Initial Assessment and Annual Review, Monthly RN Services, Homemaker Services, And Transportation.
Directions: Add this section

Chapter 501.7.12 Personal Options Participant-Directed Goods and Services

Introduction: This section defines Personal Options Participant-Directed Goods and Services
Old Policy: Did not refer to Personal Options
New Policy: Personal Options added
Change: Personal Options members may receive participant-directed goods and services up to $1000 annually.
Directions: Replace this section

Chapter 501.7.13 Personal Options Basic Training Requirements

Introduction: This section describes the basic training requirements for a Personal Options homemaker
Old Policy: Did not refer to Personal Options
New Policy: Personal Options added
Change: Personal Options training requirements for homemakers added
Directions: Add this section

Chapter 501.7.13.1 Personal Options Substitution of Basic Training Requirements

Introduction: This section describes what components of training may be waived for past course work or experience.
Old Policy: Did not refer to Personal Options
New Policy: Personal Options added
Change: Personal Options substitution of basic training requirements for homemakers added
Directions: Add this section

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Chapter 501.7.13.2 Personal Options On-going Annual Training

Introduction: This section states the personal options members may require additional training of their direct care staff
Old Policy: Did not refer to Personal Options
New Policy: Personal Options added
Change: Members may require their direct care staff to have additional training to meet the member's specific needs.
Directions: Add this section

Chapter 501.7.14 Agencies Providing Both Homemaker and Case Management Services

Introduction: This section stipulates provisions for providing both homemaker and case management services
Old Policy: Did not stipulate the need for independent staff for each service.
New Policy: Each service must have its own staff
Change: However, each service must have its own staff, for example an agency Registered Nurse may not provide both HM and CM services for the same member.
Directions: Replace this section

Chapter 501.7.15.1 Personal Options Dual Services Provision of ADW and Personal Care (PC) Services

Introduction: This section defines the process for personal options dual service provision with personal care
Old Policy: Did not refer to Personal Options
New Policy: Personal Options Added
Change: Personal Options members dual service must be prior authorized.
Directions: Add this section

Chapter 501.8 Additional Services: Private Pay

Introduction: This section details documentation requirements regarding private pay services
Old Policy: Did not refer to Personal Options
New Policy: Personal Options Added
Change: Personal Options members must document these services on the Resource Management Plan.
Directions: Replace this section

501.9 Service Options and Limitations

Introduction: This section states what services are optional and what services are mandatory for the program

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Old Policy: Did not refer to Personal Options
New Policy: Personal Options Added
Change: Homemaker services are mandatory services for personal options members.
Directions: Replace this section

501.10 Excluded Services and non-Reimbursable Situations

Introduction: This section states what services are excluded and non-reimbursable in the ADW
Old Policy: Did not refer to Personal Options
New Policy: Personal Options Added
Change: Medicaid will only reimburse for ADW services that are defined as required on the members RMP
Directions: Replace this section

501.11 Direct Care Provider Restrictions

Introduction: This section states that an ADW members spouse is prohibited from providing ADW services for the purpose of reimbursement
Old Policy: Did not refer to Personal Options
New Policy: Personal Options Added
Change: A personal options ADW member's spouse is restricted from providing ADW services to the member for the purpose of reimbursement.
Directions: Replace this section

501.12 Monitoring for Quality Assurance by BOSS

Introduction: This section states that ADW quality assurance monitoring policy
Old Policy: Did not refer to Personal Options
New Policy: Personal Options Added
Change: A personal options added to the quality assurance monitoring review process.
Directions: Replace this section

Attachment Index

Introduction: Lists all Attachments to Chapter 500.
Old Policy: Attachment 1A, 2A, 3A, 12A, 13A, 17A and 19A not included
New Policy: Attachment 1A, 2A, 3A, 12A, 13A, 17A and 19A included
Change: Include Attachment 1A, 2A, 3A, 12A, 13A, 17A and 19A
Directions: Replace this section

Attachment 1A

Introduction: Personal Options DHS-2 form
Old Policy: Did not include the Personal Options form

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New Policy: Personal Options DHS-2 form added.
Change: Personal Options members will utilize the DHS-2 form
Directions: Add this form

Attachment 2A

Introduction: Personal Options Transfer Form
Old Policy: Did not include the Personal Options form
New Policy: Personal Options transfer form added
Change: Personal Options members will utilize the personal options transfer form
Directions: Add this form.

Attachment 3A

Introduction: Personal Options Grievance Form
Old Policy: Did not include the Personal Options Grievance form
New Policy: Personal Options grievance form added
Change: Personal Options members will utilize the personal options grievance form
Directions: Add this form.

Attachment 8

Introduction: Agency and Personal Options Informed Consent and Release of Information
Old Policy: Did not include Personal Options
New Policy: Personal Options added
Change: Personal Options incorporated into consent form
Directions Replace this form.

Attachment 12A

Introduction: Personal Options Request for Level of Care Change form
Old Policy: Did not include the Personal Options Request for Level of Care Change form
New Policy: Personal Options Request for Level of Care Change form added
Change: Personal Options members will utilize the Personal Options Request for Level of Care Change form
Directions: Add this form.

Attachment 13A

Introduction: Personal Options Confidentiality Agreement
Old Policy: Did not include the Personal Options Confidentiality Agreement
New Policy: Personal Options Confidentiality Agreement form added
Change: Personal Options members will utilize the Personal Options Confidentiality Agreement form

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Directions: Add this form.

Attachment 17A

Introduction: Personal Options Incident Report
Old Policy: Did not include the Personal Options Incident Report
New Policy: Personal Options Incident Report form added
Change: Personal Options members will utilize the Personal Options Incident Report form
Directions: Add this form.

Attachment 19A

Introduction: Personal Options Dual Service Provision Request form
Old Policy: Did not include the Personal Options Dual Service Provision Request form
New Policy: Personal Options Dual Service Provision Request form added
Change: Personal Options members will utilize the Dual Service Provision Request form
Directions: Add this form.

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TOPIC **PAGE NO.**

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Attachment Index (ADW Documents)

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NOTE: Definitions and acronyms can be found in Common Chapter 200.

Chapter 501-Covered Services, Limitations, and Exclusions for Aged and Disabled Waiver Services

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all state and federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

This chapter sets forth the BMS requirements for the Aged and Disabled Waiver (ADW) Program provided to eligible West Virginia Medicaid members.

The policies and procedures set forth herein are promulgated as regulations governing the provision of ADW services by ADW providers in the Medicaid Program administered by the West Virginia Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

501.1 PROGRAM DESCRIPTION

Within the ADW program there are two options for service delivery, the traditional ADW Program and Personal Options Program.

The ADW Program is defined as a long-term care alternative that provides services that enable an individual to remain at or return home rather than receiving nursing facility (NF) care. Specifically, ADW services include Homemaker, Case Management, Consumer-Directed Case Management, Medical Adult Day Care, Transportation, and RN Assessment and Review.

Personal Options is a new self-directed option within the ADW Program. Members will have an individualized budget based on their level of care that they can utilize to purchase the following services: Homemaker, Case Management, Transportation, RN Assessment and Review and Participant Directed Goods and Services. Members will be able to hire, supervise and terminate their own workers. Members who choose Personal Options cannot self-direct Medical Adult Day Care but they can receive this service through the traditional agency option.

501.2 PROVIDER ENROLLMENT AND CERTIFICATION REQUIREMENTS, MANAGEMENT OF INCIDENTS, AND AGENCY CLOSURE

If a Case Management Agency (CMA), Homemaker Agency (HMA), Medical Adult Day Care (MADC) Agency, or any interested party requests information about becoming a certified ADW provider, they will be referred to the ADW manual on the BMS Web site. After examining the manual, the interested party must request an on-site visit by the Bureau of Senior Services (BoSS) staff to assess the certification criteria (see 501.2.B.) and provide initial program training. If the interested party is an existing ADW provider agency in good standing, the

certification review may be expedited. If the party meets certification criteria, BMS claims agent, Unisys, will then be notified as part of the enrollment process.

Personal Options, the self-directed option within the ADW Program, utilizes a Fiscal/Employer Agent-Resource Consultant (F/EA-RC) to assist self-directed members with their financial responsibilities such as payroll, and state and federal taxes as well as the responsibilities of being an employer, such as hiring and terminating workers.

A. ENROLLMENT

The BMS claims agent, Unisys, will provide the applicant with an enrollment packet, including the Provider Agreement. The applicant will return the Provider Agreement signed by an authorized applicant representative to the Bureau for Medical Services. An authorized representative from BMS will sign the Provider Agreement and return a copy to the applicant. BMS will forward a copy of the Provider Agreement to the BMS claims agent. Once this process has been completed, the claims agent will assign a provider number and send a letter informing the agency that it may begin providing and billing for ADW services. A copy of this letter is also forwarded to BoSS to allow for the inclusion on the BoSS Web site and the Freedom of Choice provider selection forms, by which members may choose a CMA and HMA.

Personal Options providers (workers hired by the member) will enter into a simplified provider agreement facilitated and signed by the F/EA-RC that is the subagent to the Bureau for Medical Services.

B. CERTIFICATION

All providers must agree to abide by applicable federal and state laws, policy manuals, policy changes, and other documents that govern this program. Providers must also agree to subject themselves, their staff, and any and all records pertaining to member services to any audit, desk review, or other service evaluation that ensures compliance with billing regulations and program goals.

Additionally, new and current providers must meet and maintain the following requirements:

1. Provide adequate qualified personnel who meet minimum criteria for providers of the ADW Program and who meet applicable licensure and/or other credentialing and training criteria. Direct care service providers must have a Criminal Investigation Background check (CIB) completed. Refer to section 501.2.1 for specific CIB policy.

Waiver providers are subject to the provisions of WV Code 15-2C-1 et seq., the Central Abuse Registry maintained by the WV State Police.

2. Maintain records that fully disclose the extent of the services provided and furnish information to BMS, or its representative, as may be requested.
3. Provide to BoSS the names of the counties the agency intends to serve and currently serves. Provider must have a permanently staffed office(s); if any office is not located in each county served, there must be at least one permanently staffed office to serve no more than eight (8) contiguous counties.
4. Maintain an agency quality assurance plan that is consistent with the Centers for Medicare & Medicaid's (CMS') quality framework and assurances. (See www.cms.hhs.gov/HCBS/downloads/qualityframework.pdf).
5. Office Criteria – There must be a physical facility(ies) for each office designated to serve no more than eight (8) contiguous counties; a post office box or commercial mailbox will not suffice. Each facility so designated must meet the following criteria:

a. Must be located within West Virginia.
b. Must have at least one entrance that is handicapped accessible to the public and accessible from the street and/or parking lot. Handicapped parking must be available.
c. Must maintain a telephone that is listed under the name and local address of the business. Exclusive use of a pager, answering service (including a telephone line that is shared with another business/individual), facsimile machine, cell phone, or answering machine does not constitute a primary business telephone but may be used after hours or for emergencies.
d. Must be open to the public at least forty (40) hours per week. Observation of state and federal holidays is at the provider's discretion.
e. Must contain space for securely maintaining member records. Appropriate medical documentation on each member must be kept by the ADW provider in the office that represents the county in which services are provided. See Common Chapter 800, ¶890 for more information on maintenance of records.
f. Must be identifiable to the public.

Personal Options has been incorporated into this section.

501.2.1 CIB POLICY AND RESTRICTIONS

Criminal Investigation Background Check (CIB) results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. At minimum, a state level criminal investigation background check must be conducted. The individual shall not be approved, employed, utilized or considered for employment if ever convicted of:

- Abduction
- Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery
- Child/adult abuse or neglect
- Crimes which involve the exploitation of a child or an incapacitated adult
- Felony Domestic battery or domestic assault
- Felony arson
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm
- Felony drug related offenses within the last 10 years
- Felony DUI within the last 10 years
- Hate crimes
- Kidnapping
- Murder/ homicide
- Neglect or abuse by a caregiver
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexual explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct
- Purchase or sale of a child
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure
- Healthcare fraud

501.2.2 PROVIDER GUIDELINES AND RESPONSIBILITIES FOR MANAGEMENT OF INCIDENTS

The West Virginia DHHR requires that all ADW providers take necessary steps to ensure the health and safety of all members served. All ADW providers shall have policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the members they serve. The provider is responsible for taking appropriate action on both an individual and systemic basis in order to prevent harm to the health and safety of all members served.

Each provider shall be responsible for ongoing development and review of policies and procedures for staff to follow in the identification, investigation, and remediation of incidents that have produced or have the potential to produce harm or risk to the safety of members served. Incidents shall be classified by the provider as one of the following:

- Allegation of abuse and/or neglect
- Critical incident
- Simple incident

The provider shall have in place procedures requiring investigation and monitoring of each level of incident. The provider may exceed the standards set forth by the guidelines set forth below.

Allegations may come directly from ADW members themselves, legal representatives, members' families, health care providers, concerned citizens, and public agencies. Report sources may be verbal or written. In some instances, the complainant may request anonymity.

All incidents shall be tracked by the provider in order to identify trends and the need to improve/amend provider policies and procedures, if necessary. Any actions necessary to address concerns identified by this process shall be incorporated into the provider's Quality Assurance Plan and provided to BoSS monitoring staff at the time of agency review.

Personal Options providers and the F/EA-RC-RC are mandatory reporters per AD waiver policy (refer to section 501.2.1) Personal Options providers must report any incidents to the F/EA-RC-RC (refer to 501.2.2.4) who has a tracking responsibility via their contract with BMS.

501.2.2.1 ALLEGATIONS OF ABUSE AND/OR NEGLECT

Mandatory Reporting:

The DHHR Adult Protective Services (APS) unit requires reporting of neglect, abuse, and suspected neglect or abuse of an incapacitated adult to Adult Protective Services. In W.Va. Code §9-6-1 (4) an "incapacitated adult" is defined as *"any person who by reason of physical, mental, or other infirmity is unable to independently carry on the daily activities of life necessary to sustaining life and reasonable health."* Additionally, as detailed in §9-6-11(a), "*a report . . . shall be made immediately by telephone to the department's local adult protective services agency and shall be followed by a written report by the complainant or the receiving agency within forty-eight hours."* DHHR's Abuse Hotline number is 1-800-352-6513.

W. Va. Code §9-6-9(a) defines who must and who may report incidents: *"If any medical, dental or mental health professional, Christian science practitioner, religious healer, social service worker, law-enforcement officer, state or regional ombudsman, humane officer or any employee of any nursing home or other residential facility has reasonable cause to believe that an incapacitated adult or facility resident is or has been neglected, abused or placed in an emergency situation, or if such person observes an abuse, neglect or an emergency situation, the person shall immediately report the circumstances pursuant to the provisions of section eleven* [§9-6-11] *of this article: Provided, That nothing in this article is intended to prevent individuals from reporting on their own behalf."*

Abuse is *"the infliction or threat to inflict physical pain or injury on or the imprisonment of any incapacitated adult or facility resident"* (§9-6-1). Any improper use of restraints or those

not authorized by physician or any use of restraints that results in injury shall be reported to Adult Protective Services, regardless of the circumstances.

Neglect is *"the failure to provide the necessities of life to an incapacitated adult"* or *"the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult"*(§9-6-1). Neglect would include the lack of or inadequate medical care by the service provider and inadequate supervision resulting in injury or harm to the incapacitated member. Neglect also includes, but is not limited to: A pattern of failure to establish or carry out a member's individualized program plan or treatment plan that results in negative outcome or places the member in serious jeopardy; a pattern of failure to provide adequate nutrition, clothing, or health care; failure to provide a safe environment resulting in negative outcome; and/or failure to maintain sufficient, appropriately trained staff resulting in negative outcome or serious jeopardy. This may also include medication errors and dietary errors resulting in a need for treatment for the member.

Additionally, Sexual Abuse and Sexual Exploitation are defined as follows:

Sexual Abuse is any of the following acts toward an incapacitated adult in which an individual engages in, attempts to engage in, or knowingly procures another person to engage in such act, notwithstanding the fact that the incapacitated individual may have suffered no apparent physical injury as a result of such conduct: 1) Sexual intercourse/intrusion/contact; and 2) Any conduct whereby an individual displays his/her sex organs to an incapacitated adult for the purpose of gratifying the sexual desire of that individual, of the person making such display, or of the incapacitated adult, or for the purpose of affronting or alarming the incapacitated adult.

Sexual Exploitation is when an individual, whether for financial gain or not, persuades, induces, entices, or coerces an incapacitated adult to display his/her sex organs for the sexual gratification of that individual or third person, or to display his/her sex organs under circumstances in which that individual knows such display is likely to be observed by others who would be affronted or alarmed.

All of the above mandatory reporting information also applies to Personal Options.

501.2.2.2 CRITICAL INCIDENTS

Critical incidents are defined as those incidents with a high likelihood of producing real or potential harm to the health and welfare of the ADW member. Critical incidents do not involve abuse or neglect. These incidents might include, but are not limited to, the following:

- Attempted suicide, or suicidal threats or gestures.

- Suspected and/or observed criminal activity by members themselves, members' families, health care providers, concerned citizens, and public agencies that does not compromise the health or safety of the member.
- An unusual event such as a fall or injury of unknown origin requiring medical intervention if abuse and neglect is not suspected.
- A member's residence that has a significant interruption of a major utility, such as electricity or heat, but does not compromise the health or safety of the member.
- Environmental/structural problems with the member's home, including inadequate sanitation or structural damage that does not compromise the health or safety of the member.
- Fire in the home resulting in relocation or property loss that does not compromise the health or safety of the member.
- Unsafe physical environment in which the homemaker and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy.
- Disruption of the delivery of ADW services, due to involvement with law enforcement authorities by the ADW member and/or others residing in the member's home that does not compromise the health or safety of the member.
- Medication errors by a member or his/her family caregiver that do not compromise the health or safety of the member, such as medication taken that was not prescribed or ordered for the member, and failure to follow directions for prescribed medication, including inappropriate dosages, missed doses, or doses administered at the wrong time.
- Disruption of planned services for any reason that does not compromise the health or safety of the member, including failure of member's emergency backup plan.
- Any other incident judged to be significant and potentially having a serious negative impact on the member, but does not compromise the health or safety of the member.
- Any incident attributable to the failure of ADW provider staff to perform his/her responsibilities that compromises the health or safety of the member is considered to be neglect and must be reported to Adult Protective Services. Any time abuse or neglect is suspected, it **must** be reported to Adult Protective Services.

All of the above critical incident information also applies to Personal Options.

501.2.2.3 SIMPLE INCIDENTS

A simple incident is defined as any unusual event occurring to a member that cannot be characterized as a critical incident and does not meet the level of abuse or neglect. Examples of simple incidents include, but are not limited to, the following:

- Minor injuries of unknown origin with no detectable pattern
- Dietary errors with minimal or no negative outcome

All of the above simple incident information also applies to Personal Options.

501.2.2.4 DOCUMENTATION AND INVESTIGATION PROCEDURES

The provider shall ensure that the Incident Report (Attachment 17) is completed to the maximum extent possible. Providers shall designate either a Registered Nurse (RN), Licensed Social Worker, or Licensed Counselor—unless there is a conflict of interest—to immediately review each Incident Report and determine whether the incident warrants a thorough investigation. Investigations shall be initiated within twenty-four (24) hours of learning of the incident. If requested by Adult Protective Services, a provider shall delay its own investigation and document such request on the Incident Report.

Witnesses shall be interviewed, including the ADW member and/or staff involved. The interview will be face-to-face unless circumstances do not permit. Such circumstances shall be documented in the Incident Report. At any time during the course of the investigation should an allegation or concern of abuse or neglect arise, the provider shall immediately notify Adult Protective Services.

An Incident Report should be completed within fourteen (14) calendar days of the incident and submitted to the provider's director for review and sign-off. The provider will maintain all Incident Reports in an administrative file. At a minimum, the Incident Report shall include:

- A factual account of the incident
- Findings and conclusions (including any antecedents that potentially triggered the incident)
- Details of actions taken by the provider, if any
- Any staff training that might be helpful in preventing further incidents
- Any recommendations for additional support of the ADW member
- Any recommended modifications(s) to the member's Service Coordination Plan (SCP) or Plan of Care (POC)

The provider shall be responsible for tracking all incidents and for taking appropriate action when needed.

A. **Abuse and/or Neglect, Sexual Abuse and Sexual Exploitation**
As mandated in ¶501.2.3, abuse, neglect, and exploitation must be reported to Adult Protective Services. The Incident Report must also be completed. This incident reporting mechanism in no way supersedes the reporting of incidents to Adult Protective Services. If abuse, neglect, or an emergency situation is suspected or known, state law mandates that the party having this suspicion or knowledge report this to Adult Protective Services. Adult Protective Services is responsible for investigation of the

allegations. In emergency/life-threatening situations, the investigation is to be initiated within two hours. Non-emergency situations are to be initiated within seventy-two (72) hours or within fourteen (14) days, depending on the severity of the situation and the potential for danger. The contact with Adult Protective Services may be made anonymously, but the member's file must contain the documentation of the alleged abuse or neglect, and state the appropriate report has been made.

B. **Critical Incident:** If a Critical Incident (as defined in ¶501.2.2.1) occurs, the provider must thoroughly investigate the incident and complete the Incident Report.

C. **Simple Incident:** If an incident is determined to be a Simple Incident (as defined in ¶501.2.2.2) and there is no need for further investigation, the provider must complete the Incident Report and indicate that no investigation was needed

For Personal Options, members' providers shall ensure that the Personal Options incident report
(Attachment 17A) is completed to the extent possible, submitted to the F/EA-RC and it will be maintained in the F/EA-RC file.

501.2.2.5 TRACKING AND MONTHLY/ANNUAL REPORTING OF INCIDENTS

The provider shall track all incidents and report the results monthly to the West Virginia Bureau of Senior Services using the Agency Monthly Incident Tracking Report (Attachment 18). Member hospitalizations should only be reported by the HMA on the Monthly Incident Tracking Report. Electronic reporting will be mandatory when available.

For purpose of agency self-review, an annual Incident Report must be developed as part of agency quality assurance. The provider shall review/assess all relevant policies and procedures and suggestions for any changes to provider policies and procedures or implementation of procedures that might be helpful in preventing similar incidents.

Personal Options providers will submit incident reports to the F/EA-RC (Refer to 501.2.2 and 501.2.2.3). The F/EA-RC has a tracking/reporting responsibility defined in their contract with BMS.

501.2.3 AGENCY CLOSURE

A provider may terminate participation in the ADW Program with thirty (30) days written notification of voluntary termination; the termination notification must be submitted to BMS claims agent, Unisys, and to BoSS.

A Personal Options provider and/or member must notify the F/EA-RC when a worker terminates participation as a Personal Options provider.

501.2.3.1 AGENCY CLOSURE - CASE MANAGEMENT AGENCY

Upon written notification that a CMA intends to cease participation in the ADW Program, BoSS will advise the Quality Improvement Organization (QIO) to send another Freedom of Choice Case Management Selection Form to each of the CMA's members, along with a cover letter explaining the reason a new CMA selection must be made. If at all possible a joint visit with the member will be made by both the CMA that is ceasing participation and the new one selected in order to explain the transfer process. In every case, the CMA terminating participation will ensure that the transfer of the member is accomplished as expeditiously as possible.

Not applicable to Personal Options.

501.2.3.2 AGENCY CLOSURE - HOMEMAKER AGENCY

Upon written notification that a HMA intends to cease participation in the ADW Program, BoSS will contact the agency terminating services to ensure that the CMA of record for each member has been contacted by the HMA. The CMA will contact each member and have a new Freedom of Choice HMA Selection Form completed. If at all possible, a joint home visit will be made with the member by the HMA that is ceasing participation and the new one selected in order to explain the transfer process. In every case, the HMA terminating participation will ensure that the transfer of the member is accomplished as expeditiously as possible.

Not applicable to Personal Options.

501.2.3.3 AGENCY CLOSURE - ADMINISTRATIVE (INVOLUNTARY) CLOSURE

BMS may administratively terminate a provider from participation with thirty (30) days written notification. BMS may also cancel a contract immediately or give notification in the event of a breach of the contract by the provider as specified in the Provider Enrollment Agreement. Such action precludes further payment by BMS for services provided to members subsequent to the date specified in the termination notice. See Common Chapter 800 for more information on this procedure.

All of the above administrative agency closure information also applies to Personal Options.

501.3 MEMBER ELIGIBILITY AND ENROLLMENT PROCESS

Applicants for the ADW Program must meet all of the following criteria to be eligible for the program:

A. Be 18 years of age or older.
B. Be a permanent resident of West Virginia. The individual may be deinstitutionalized from a NF in any county of the state, or in another state, as long as his permanent

residence is in West Virginia.

C. Be approved as medically eligible for NF Level of Care.
D. Meet the Medicaid Waiver financial eligibility criteria for the program as determined by the county DHHR office, or the Social Security Administration (SSA) if an active SSI (Supplemental Security Income) recipient.
E. Choose to participate in the ADW Program as an alternative to NF care.

Even if an individual is medically and financially eligible, a waiver allocation must be available for him/her to participate in the program.

All of the above member eligibility and enrollment process information also applies to Personal Options.

501.3.1 MEDICAL ELIGIBILITY

A QIO under contract to BMS determines medical eligibility for the ADW Program.

All of the above medical eligibility information also applies to Personal Options.

501.3.1.1 PURPOSE

The purpose of the medical eligibility review is to ensure the following:

A. New applicants and existing members are medically eligible based on current and accurate evaluations.
B. Each applicant/member determined to be medically eligible for ADW services receives an appropriate LOC that reflects current/actual medical condition and short- and long-term service needs.
C. The medical eligibility determination process is fair, equitable, and consistently applied throughout the State.

All of the above purpose information also applies to Personal Options.

501.3.2 MEDICAL CRITERIA

An individual must have five (5) deficits on the Pre-Admission Screening Form (PAS), Attachment 14, to qualify medically for the ADW Program. These deficits are derived from a combination of the following assessment elements on the PAS.

Section	Description of Deficits
#24	Decubitus; Stage 3 or 4
#25	In the event of an emergency, the individual is c) mentally unable or d) physically unable to vacate a building. a) Independently and b) With

Section	Description of Deficits	
	Supervision are not considered deficits.	
#26	Functional abilities of individual in the home	
a.	Eating	Level 2 or higher (physical assistance to get nourishment, not preparation)
b.	Bathing	Level 2 or higher (physical assistance or more)
c.	Dressing	Level 2 or higher (physical assistance or more)
d.	Grooming	Level 2 or higher (physical assistance or more)
e. f.	Continence, bowel Continence, bladder	Level 3 or higher; must be incontinent.
g.	Orientation	Level 3 or higher (totally disoriented, comatose).
h.	Transfer	Level 3 or higher (one-person or two-person assistance in the home)
i.	Walking	Level 3 or higher (one-person assistance in the home)
j.	Wheeling	Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home. Do not count outside the home.)
#27	Individual has skilled needs in one or more of these areas: (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations.	
#28	Individual is not capable of administering his/her own medications.	

All of the above medical criteria information also applies to Personal Options.

501.3.2.1 LEVELS OF CARE CRITERIA

There are four levels of care for homemaker services. Points will be determined as follows, based on the following sections of the PAS:

Section	Description of Points
#23	Medical Conditions/Symptoms – 1 point for each (can have total of 12 points)
#24	Decubitus - 1 point
#25	1 point for b., c., or d.
#26	Functional Abilities Level 1 - 0 points Level 2 - 1 point for each item a. through i. Level 3 - 2 points for each item a. through m.; i. (walking) must be equal

Section	Description of Points
	to or greater than Level 3 before points given for j. Wheeling. Level 4 - 1 point for a., 1 point for e., 1 point for f., 2 points for g. through m.
#27	Professional and Technical Care Needs - 1 point for continuous oxygen
#28	Medication Administration - 1 point for b. or c.
#34	Dementia - 1 point if Alzheimer's or other dementia
#35	Prognosis – 1 point if Terminal

Total number of points possible is 44.

All of the above levels of care criteria information also applies to Personal Options.

501.3.2.2 LEVELS OF CARE SERVICE LIMITS

Level	Points Required	Hours Per Day	Hours Per Month
A	5-9	2	62
B	10-17	3	93
C	18-25	4	124
D	26-44	5	155

The total number of hours may be used flexibly within the month, but must be justified and documented on the POC. Example: If the POC shows 4 hours/day, Monday-Thursday and 5 hours on Friday, the additional hour on Friday must be justified on POC.

Personal Options Monthly Budget

Level	Points Required	Monthly Budget
A	5-9	$812.54
B	10-17	$1134.00
C	18-25	$1455.47
D	26-44	$1776.94

The Personal Options monthly budget can be used flexibly within the month but must be justified and documented on the approved Resource Management Plan/Spending Plan. The Personal Options monthly budget does not reflect the 15% administrative fee for the F/EA-RC.

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501.3.3 ELIGIBILITY PROCESS

In order to be eligible for the ADW program, an individual must meet both Medical and Financial Eligibility.

All of the above eligibility process information also applies to Personal Options.

501.3.3.1 INITIAL MEDICAL EVALUATION

Following is an outline of the initial medical evaluation process:

A. An applicant shall initially apply for the ADW by having his/her treating physician (M.D. or D.O. only) submit a Medical Necessity Evaluation Request form (Attachment 15) by fax or mail. The physician's signature is valid for sixty (60) days. The referral source for the request may be from the applicant/applicant's representative, hospital or nursing home, DHHR, the physician, social services agencies, or others.
B. The Medical Necessity Evaluation Request form asks that the physician submit the applicant's identifying information including, but not limited to, the following:
   1. Medical diagnosis and any comments
   2. Other pertinent medical conditions
   3. Identification of whether the applicant has Alzheimer's, multi-infarct, senile dementia, or related conditions
   4. Terminal prognosis

C. Once a referral is received, the QIO will send a letter of verification of its receipt to the applicant/applicant's representative and the referring physician. If the Medical Necessity Evaluation Request form is incomplete it will be returned to the physician for completion and resubmission, and the applicant will be notified. An RN from the QIO will attempt to contact the applicant/applicant's representative to schedule a home visit, allowing at least two weeks notification before the evaluation. The RN will make up to three attempts to contact the applicant. If it is determined that the applicant is not available, the referring physician and applicant/applicant's representative will be notified that no contact can be made, and no further action will be taken unless a new referral is made to the QIO.
D. If contact is made, a letter will be sent to the applicant and contact person noting the contact was made and the date of the initial evaluation, allowing at least two weeks notice. If the applicant has identified a guardian or legal representative, no home visit shall be scheduled without presence of the guardian, contact person, or legal representative. If the Medical Necessity Evaluation Request form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition, no home visit will be scheduled without the guardian, contact person, or legal representative present to assist the applicant during the interview.

E. When the home visit is made, the QIO RN, through observation and/or interview process, completes the PAS (Attachment 14). The RN will record observations and findings regarding the applicant's level of function in the home. RNs do not render medical diagnoses. In those cases where there is a medical diagnosis question, the QIO RN will attempt to clarify the information with the referring physician. In the event that the RN cannot obtain the information, he/she will document such, noting that supporting documentation from the referring physician was not received.

All of the above initial medical evaluation information also applies to Personal Options.

501.3.3.2 RESULTS OF INITIAL MEDICAL EVALUATION

A. Approval

If the applicant is determined medically eligible, a notice of approved medical eligibility is sent to the applicant, the referring physician, and applicant's representative, if applicable. When an allocation becomes available in the ADW Program, a second notice of approved medical eligibility, which includes the maximum number of in-home care hours, is sent to the applicant, referring physician, and applicant's representative, if applicable. A copy of the applicant's PAS is also sent at this time to the applicant or representative, if applicable.

Additionally, the QIO sends a Freedom of Choice Case Management Selection Form to the applicant, advising of the applicant's need to choose a case management agency, Personal Options, or the self-directed case management option. This is also sent to the applicant's representative, if applicable. The Case Management Selection Form lists all CMAs in the applicant's county. It is to be returned to the QIO once a selection is made. Should the applicant indicate "No Choice" on the Case Management Selection Form, BoSS will be notified by the QIO, and BoSS will assign the applicant a CMA; the agency is selected on a rotating basis. Once a CMA has been selected, either by the applicant or BoSS, the QIO will notify that agency and send the agency a copy of the applicant's PAS. If Personal Options has been selected the QIO will notify the Bureau of Senior Services and send a copy of the PAS to the Bureau of Senior Services.

Personal Options information has been incorporated into the section above.

B. Denial

If it is determined that the applicant does not meet medical eligibility, the applicant, the referring physician, and applicant's representative, if applicable, will be notified by a "Potential Denial" letter. This letter will advise the applicant of the reason for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the PAS and ADW policy will also be included with the "Potential Denial" letter. The applicant will be given two

weeks to submit supplemental medical information to the QIO; supplemental information received by the QIO is given to the reviewing RN. Information submitted after the two-week period will not be considered.

If the review of the supplemental information by the QIO determines that there is still no medical eligibility, the applicant, referring physician, and any identified representative will be notified by a "Final Denial" letter. The "Final Denial" letter will provide the reason for the adverse decision. It will also include the applicable ADW policy manual section(s), a copy of the PAS, supplemental information documentation (if it has been supplied), notice of free legal services, and a Request for Hearing form (Attachment 16) to be completed if the applicant wishes to contest the decision.

If the applicant's medical eligibility is denied and the applicant is subsequently found medically eligible after the fair hearing process, the date of eligibility can be no earlier than the effective date of the hearing decision.

All of the denial information also applies to Personal Options.

501.3.4 MEDICAL REEVALUATION

Annual reevaluations for medical necessity for each ADW member must be conducted. The process is as follows:

A. The member and/or his CMA must submit an updated Medical Necessity Evaluation Request form (Attachment 15) and any updated and pertinent medical documentation provided by the member's treating physician. The treating physician (an M.D. or D.O. only) must sign the Medical Necessity Evaluation Request. Original signatures are required; i.e., "signature of member on file" is not acceptable. The physician's signature is valid for sixty (60) days. The request can be submitted up to three (3) months prior to the annual date, and no later than forty-five (45) days prior to the expiration of the current approved PAS. A reevaluation request not made at least forty-five (45) days prior to the PAS expiration risks the member's medical eligibility. BMS cannot pay CMAs, HMAs, or MADC's for services provided to a medically ineligible member. Recoupment of service payment will be made from the agency(ies). (See Common Chapter 800 for further information.) Additionally, the expiration of a PAS does not constitute a reason for member appeal.
B. After receiving the Medical Necessity Evaluation Request form and any other relevant medical documentation from the member's treating physician, the member, or CMA, a QIO RN will attempt to contact the member or identified representative. If the applicant has identified a guardian or legal representative, no home visit shall be scheduled without presence of the guardian, contact person, or legal representative. If the request indicates that the member has Alzheimer's, multi-infarct, senile

dementia, or related condition, no home visit will be scheduled without the guardian, contact person, or legal representative present to assist the member in the interview.

C. If the QIO RN makes the contact, a letter is sent to the member, CMA (if applicable), and identified representative noting the contact and date of the home visit, allowing at least two weeks notice. When the home visit is made, the QIO RN, through observation and/or interview process, completes the PAS (Attachment 14). The RN will record observations and findings regarding the member's level of function in the home. RNs do not render medical diagnoses.
D. In those cases where there is a medical diagnosis question, the QIO RN will attempt to clarify the information with the referring physician. In the event that the RN cannot obtain the information, he/she will document such, noting that supporting documentation from the referring physician was not received.
E. If the QIO RN is unable to contact the member, a letter will be sent to the member, CMA, referring physician, and member's representative, if applicable, stating that an updated Medical Necessity Evaluation Request must be submitted.

All of the above information on medical reevaluation also applies to Personal Options.

501.3.4.1 RESULTS OF MEDICAL REEVALUATION

A. Approval
If the member meets the medical eligibility criteria, a Notice of Approved Continued Medical Eligibility" is sent to the member, identified representative, the CMA and the Personal Options Fiscal/Employer Agent- RC if applicable. This notice includes the approved Level of Care and the maximum number of hours of service per month, a notice of free legal services, and a Request for Hearing form (Attachment 16).
B. Denial
If it is determined that the member does not meet medical eligibility, the member, the referring physician, the Personal Options Fiscal/Employer Agent- RC, and member's representative, if applicable, will be notified by a Potential Denial letter. This letter will advise the member of the reason(s) for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the PAS and ADW policy will also be included with the "Potential Denial" Letter. The member will be given two weeks to submit supplemental medical information to the QIO; supplemental information received by the QIO is given to the reviewing RN. Information submitted after the two-week period will not be considered.

If the review of the supplemental information by the QIO determines that there is still no medical eligibility, the member, referring physician, and any identified representative will be notified with a "Final Denial" letter. The "Final Denial" letter will provide the reason for the adverse decision. It will also include the applicable policy manual section(s), a copy of the PAS, supplemental information documentation (if it

has been supplied), notice of free legal services, and a Request for Hearing (Attachment 16) to be completed if the applicant wishes to contest the decision. If the member elects to appeal any adverse decision, benefits shall continue at the current level only if the appeal is mailed within thirteen (13) days of the notice date, and only until a final decision is rendered by the administrative Hearing Officer.

Personal Options information has been incorporated into the section above.

501.3.5 PERIODIC MEDICAL REEVALUATION

The decision to conduct a periodic medical reevaluation will be made by the QIO RN. This decision will be made based on the applicant's/member's medical condition at the time of the medical necessity evaluation and the progress applicant/member is expected to make. Depending upon the member's medical condition, the periodic reevaluation would be scheduled at a specified time interval, such as after six weeks, three months, six months, and so forth.

The above information on periodic medical reevaluation also applies to Personal Options.

501.3.6 FINANCIAL ELIGIBILITY

The county DHHR office makes financial eligibility determinations. Factors such as income and assets are taken into consideration when determining eligibility. An applicant's/member's gross monthly income may not exceed 300% of the current maximum SSI payment per month for participation in the ADW Program. Only the income of the applicant/member is considered, not the income of the spouse, parents, or family.

If an individual is not an active Medicaid recipient at the time that medical eligibility is approved the Case Manager (CM) or Consumer-Directed Case Manager is responsible for ensuring that a financial application is made at the county DHHR office. A copy of the "Eligibility Determination" page of the PAS, which establishes the applicant's medical eligibility, must be attached to the DHS-2 form (see Attachment 1) that is provided in person or by mail to the county DHHR office. Financial eligibility cannot be initiated for ADW coverage without both documents. When an applicant chooses Consumer-Directed Case Management, BoSS will attach the "Eligibility Determination" page of the PAS to the DHS-2 and send directly to the applicant/applicant's representative to be taken or forwarded to the county DHHR office.

ADW providers will not be paid for services before the date on which an applicant's financial eligibility is established.

For Personal Options, if an individual is not an active Medicaid recipient at the time that medical eligibility is approved, the Personal Options member is responsible for ensuring that a financial application is made at the county DHHR office. A copy of the "Eligibility Determination" page of the PAS, which establishes the applicant's medical eligibility, must be attached to the DHS-2

form (see Attachment 1A) that is provided in person or by mail to the county DHHR office. Financial eligibility cannot be initiated for ADW coverage without both documents. When an applicant chooses Personal Options, BoSS will attach the "Eligibility Determination" page of the PAS to the DHS-2 and send directly to the applicant/applicant's representative to be taken or forwarded to the county DHHR office.

501.4 MEMBER RESPONSIBILITIES, TRANSFER, AND DISCONTINUATION OF SERVICES

In addition to the following, see Common Chapter 400, ¶470 for further information about Member Rights and Responsibilities.

501.4.1 MEMBER RESPONSIBILITIES

The responsibilities of ADW members include, but are not limited to, the following:

A. **Member Refusal of Services**
It is the member's/member representative's responsibility to notify the HMA within twenty-four (24) hours prior to the day services are to be provided if services are not needed. A revision to the Service Coordination Plan/Plan of Care may be needed if canceling services becomes a pattern with the member, and the HMA must notify the CMA if applicable. A member's consistent refusal of services may lead to termination of all program services.
Not applicable to Personal Options.

B. **Home Visits**
As a condition of participation in the ADW program the member agrees to in-home visits by BMS, BoSS, CMA, HMA, QIO staff, and for Personal Options the F/EA-RC which may be necessary in order to provide, monitor, and ensure the quality of services. Visits will be scheduled with notice and at a time of mutual availability. It is the member's responsibility to answer questions and/or demonstrate functional abilities, if at all possible, during the medical assessment visit. Consistent refusal to allow these visits will result in termination of all program services.

C. **Change in Status or Residence**
The member/member's representative has the responsibility to notify the CMA, HMA and for Personal Options the F/EA-RC immediately upon any change in status or residence that will require suspension or relocation of services. This includes admission to an acute care hospital, NF, or rehabilitation facility; any change of residency; change in medical status; or other change that will impact scheduled homemaker services. On return from a hospital or other admission, the HMA or for Personal Options the F/EA-RC must be notified to arrange reinstatement of services, if applicable.

D. **Agency-to-Agency Transfer**
It is the member's/member representative's responsibility to notify the current CMA,

HMA, or BoSS if the member wants to transfer to a different provider agency. It is then the provider's or BoSS's responsibility to provide the member with a Member Request to Transfer (Attachment 2). (See ¶501.4.2 for more information.). Agency-to Agency Transfer is not applicable to Personal Options.

E. **Personal Options Transfer** – The member or member's representative has the responsibility to notify BoSS if the member wants to transfer from Personal Options to an agency or from an agency to Personal Options. It is then BoSS responsibility to provide the member with a Personal Options Transfer Form (Attachment 2A).

F. **Payment for Services**
Medicaid will not pay for any ADW services received until the individual is approved for the ADW Program. This information on payment for services is also applicable to Personal Options.

G. **Homemaker Worksheet**
It is the member's responsibility to verify services received from the homemaker (HM) by initialing and signing the HM worksheet. In Personal Options members must verify services received by completing required documentation.

H. **Request for Additional Hours of Service**
It is the member's responsibility to sign a "Request for Level of Care Change" and/or "Dual Service Provision Request." This information on a request for additional hours of service is also applicable to Personal Options.

Personal Options information has been incorporated into the section above.

501.4.2 TRANSFER TO DIFFERENT AGENCY

An ADW member is permitted to change provider agencies. If a member wishes to transfer, he must notify his current CMA, HMA, or BoSS. That agency will immediately assist the member in the completion of a Member Request to Transfer (Attachment 2). Once completed, this form, signed by the member, will be forwarded by the member or provider to BoSS. Upon receipt of the form, BoSS will contact the member to discuss the reasons surrounding the transfer request. BoSS will then send the member a HMA or CMA Freedom of Choice Selection Form, whichever is applicable; once this form is returned to BoSS, BoSS will coordinate between the two transferring agencies.

BoSS will set the effective date of the transfer. To allow for equity in billing between the transferring agencies, the effective date will be the first day of a month. The effective date will be contingent upon the receipt at BoSS of the member's signed Request to Transfer and the subsequent receipt of the signed CMA or HMA Freedom of Choice Selection Form. If the selection form is received in time for all agency information to be transferred from the "old" agency to the "new" agency by the first of the next month, it shall be done. For example, BoSS receives a signed transfer request between May 1 and May 15. The agency selection form is subsequently received in a timely manner and the transfer of information can be affected smoothly; therefore, the effective date of transfer will be June 1. If the signed request is

received after May 15, the effective date may be July 1. At no time should the transfer take more than forty-five (45) days from the date that the member-signed transfer request is received at BoSS, unless there is an extended delay by the member in returning the selection form. BoSS staff will make every effort to ensure the expedient return of this form.

Once BoSS completes the transfer coordination, the former agency will provide the receiving agency the member's records (copies) including the PAS, DHS-2, assessments, SCP, POC, and other pertinent information. The former agency must keep the originals of these documents for audit purposes.

When a member transfers homemaker agencies, the receiving agency RN cannot bill for an Initial Assessment (billing code T1001, Modifier UD) if one has been completed within the calendar year (January - December).

Personal Options Transfers: An ADW member is permitted to change from a provider agency to Personal Options or from Personal Options to a provider agency. If a member wishes to transfer he/she must notify BoSS. BoSS will send the member a Personal Options Transfer Form (Attachment 2A). Once completed, this form, signed by the member is to be sent to BoSS. Upon receipt of the form, BoSS will contact the member to discuss the reasons surrounding the transfer request. BoSS will then send the member a CMA Freedom of Choice Selection form, if applicable. Once the form is returned to BoSS, BoSS will coordinate the transfer.

BoSS will set the effective date of the transfer. The effective date will be the first date of the next month if the transfer is received by the 17th of the month. The effective date will be contingent upon the receipt at BoSS of the members signed request to transfer and the subsequent receipt of the signed CMA Freedom of Choice Selection Form, if applicable.

At no time should the transfer take more than forty-five (45) days from the date that the member-signed transfer request is received at BoSS, unless there is an extended delay by the member in returning the selection form. BoSS staff will make every effort to ensure the expedient return of this form.

Once BoSS completes the transfer coordination, if transferring from an agency to Personal Options, the agency will provide the members records to the members and/or their representative. If transferring from Personal Options to an agency, the member will provide the members records to the agency.

501.4.3 EMERGENCY TRANSFERS

A request to transfer that is considered to be an emergency, such as when a member suffers abuse, neglect, or harm, will be reviewed by BoSS, and BoSS will determine the appropriate avenue of action to be taken. The, CMA, HMA (the agency that member is transferring from) or

the Personal Options member/representative must submit supporting documentation that explains why the member is in emergency status. BoSS will waive the time frames in ¶501.4.2 and expedite the request as necessary, coordinating with the member and agencies involved.

Personal Options information has been incorporated into the section above.

501.4.4 DISCONTINUATION OF SERVICES

Notice for discontinuation of a member's services must be sent to BoSS. Notice must contain the following information: date, agency name and address (if applicable), name and title of person sending notice, name and address of member, representative, and/or Power of Attorney, reason for closure, and last date of service. The following are reasons for discontinuation of a member's ADW services. Please see Common Chapter 400, ¶480 for information about the fair hearing process.

REASON	EFFECTIVE DATE	PROCEDURE
Death	Date of Death.	CM notifies BoSS on monthly report, or immediately if Consumer-Directed CM. CM notifies county DHHR office. Personal Options F/EA-RC notifies BoSS on monthly report.
Move Out of State	Date of Move.	CM notifies BoSS on monthly report, or immediately if Consumer-Directed CM. CM notifies county DHHR office. Personal Options F/EA-RC notifies BoSS and DHHR office.
Medically Ineligible	13 days after the date of the notification letter, if member does not request hearing.	QIO sends medical ineligibility notification letter and fair hearing rights to member and the referring physician. For Personal Options, the QIO sends medical ineligibility notification to the referring physician, the member and their representative if applicable and the F/EA-RC if it is a re-evaluation. The QIO also sends fair hearing rights to the member and their representative if applicable.
Financially Ineligible	As determined by DHHR policy.	DHHR sends appropriate notification letter to member. For Personal Options, DHHR sends the

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REASON	EFFECTIVE DATE	PROCEDURE
		appropriate notification letter to the member.
Member No Longer Desires Services	13 days after the date of the notification letter, if member does not request hearing	CM immediately notifies BoSS. BoSS sends notification of discontinuation of services and fair hearing rights to member. BoSS ensures that CMA, HMA, and BMS are notified as appropriate. For Personal Options, the member immediately notifies BoSS or the F/EA-RC. BoSS sends notification of discontinuation of services and hearing rights to the member. BoSS ensures that BMS is notified.
No Services Have Been Provided for 100 continuous days; for example, extended placement in long-term care or rehabilitation facility	13 days after the date of the notification letter, if member does not request hearing.	CMA or HMA immediately notifies BoSS. BoSS sends notification of discontinuation of services and fair hearing rights to member. BoSS ensures that CMA, HMA, and BMS are notified as appropriate. For Personal Options, the F/EA-RC immediately notifies BoSS. BoSS sends notification of discontinuation of services and fair hearing rights to member. BoSS ensures that BMS is notified.
*Unsafe Physical Environment	13 days after the date of the notification letter, if member does not request hearing.	CMA or HMA notifies BoSS in writing the reasons for discontinuation of services and the steps taken. BoSS sends notification of discontinuation of services and fair hearing rights to member. BoSS ensures that CMA, HMA and BMS are notified as appropriate. For Personal Options, the F/EA-RC notifies BoSS in writing the reasons for discontinuation of services and the steps taken. BoSS sends notification of discontinuation of services and fair hearing rights to member. BoSS ensures that the F/EA-RC and BMS are notified as appropriate.

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REASON	EFFECTIVE DATE	PROCEDURE
** Member Non-Compliance with Program	13 days after the date of the notification letter, if member does not request hearing.	CMA or HMA notifies BoSS in writing the reasons for discontinuation of services and the steps taken. BoSS sends notification of discontinuation of services and fair hearing rights to member. BoSS ensures that CMA, HMA and BMS are notified as appropriate. For Personal Options, the F/EA-RC notifies BoSS in writing the reasons for discontinuation of services and the steps taken. BoSS sends notification of discontinuation of services and fair hearing rights to member. BoSS ensures that the F/EA-RC and BMS are notified as appropriate.
***Deteriorating Condition and Potential for Injury	13 days after the date of notification letter, if member does not request hearing.	CMA or HMA notifies BoSS in writing the reasons for discontinuation of services and the steps taken. BoSS sends notification of discontinuation of services and fair hearing rights to member. BoSS ensures that CMA, HMA and BMS are notified as appropriate. For Personal Options, the F/EA-RC notifies BoSS in writing the reasons for discontinuation of services and the steps taken. BoSS sends notification of discontinuation of services and fair hearing rights to member. BoSS ensures that the F/EA-RC and BMS are notified as appropriate.

* Unsafe Physical Environment: An unsafe physical environment is one in which the homemaker and/or other agency staff are threatened or abused and the staff's welfare is in jeopardy. This may include, but is not limited to, the following circumstances:

A. The member, his informals, household members, or others repeatedly demonstrate sexually inappropriate behavior; display verbally and/or physically abusive behavior; and/or threaten a homemaker or other agency staff with guns, knives, or other potentially dangerous weapons, including menacing animals.

B. The member, his informals, household members, or others display an abusive use of alcohol and/or drugs.
C. In cases of danger to staff, services may be discontinued immediately.

** Member Non-Compliance with Program: The member is persistently non-compliant with the POC.
*** Deteriorating Condition and Potential for Injury: A provider is unable to meet the needs of a member whose deteriorating condition, without an informal support system in place, results in physical injury or the potential for injury. Provider may request that member choose another provider agency, if that agency is able to fulfill the needs of member. Provider may assist in making appropriate arrangements with the member for transfer to an institution or other appropriate care. All such arrangements must continue to assure that the member exercises his freedom of choice of qualified providers.

It must be noted that termination of the Medicaid benefit itself (e.g., the medical card) always requires a 13-day advance notice prior to the first of the month Medicaid stops. Coverage always ends the last day of a month. Examples: 1) Advance notice for termination is dated January 27, Medicaid would end February 28. 2) Advance notice is dated January 16, Medicaid ends January 31. This is true regardless of when ADW services end.

Personal Options information has been incorporated into the section above.

501.5 MEMBER GRIEVANCE PROCESS

Members who are dissatisfied with the services they receive from a provider agency or the F/EA-RC have a right to file a grievance about the provision of services. All ADW service provider agencies or the F/EA-RC will afford an opportunity to all members to utilize a grievance procedure. The QIO RN will explain the grievance procedure to all applicants/members at the time of initial application/reevaluation; members will be provided with a Member Grievance Form (Attachment 3) and a Personal Options Grievance Form (Attachment 3A) at that time. Members may also request a grievance form from BoSS or any ADW service provider agency. Service providers will only afford members a grievance procedure for services that fall under the particular service provider's authority; for example, a CMA will not conduct a grievance procedure for HMA activities, nor will a HMA conduct a grievance procedure for CMA activities. The grievance procedure will be comprised of two levels:

A. **First Level: ADW Service Provider or Personal Options F/EA-RC**
When a member requests to file a grievance because of his dissatisfaction with provision of services, he will be granted a meeting, either by telephone or face-to-face, with the ADW service provider director or designee or the F/EA-RC if applicable. This meeting will be arranged within ten (10) working days from the date that the member makes the initial request or from the date on the Member Grievance Form. After being apprised of the member's grievance the ADW service provider or

F/EA-RC if applicable will offer a decision based on a professional assessment of the situation. If the member is dissatisfied with the results of the first level decision, he may request that the grievance form be submitted to BoSS, beginning the second level process. The service provider or F/EA-RC will assist the member in making the request to BoSS. The service provider or F/EA-RC will maintain a file on all grievances.

B. **Second Level: BoSS**
If an ADW service provider or F/EA-RC is not able to address the grievance in a manner satisfactory to the member and the member requests a review at the second level, BoSS will, within ten (10) days of the receipt of the Member Grievance Form, contact the member/member representative and the ADW service provider agency or F/EA-RC, review the first level grievance, and issue a second level decision.

Personal Options information has been incorporated into the section above.

501.6 MEMBER SERVICES AND SUPPORTS

Federal regulations governing Medicaid coverage of home-and community-based services under an approved waiver specify that services provided under waiver authority must be targeted to individuals who would otherwise be eligible for placement in a long-term care facility. ADW and the acute care services provided must cost less than or be equal to the cost of nursing facility care and acute care costs for the same population. The individual must be both financially and medically eligible for the ADW Program and an allocation must be available.

The waiver services that are available to ADW members are Case Management, Consumer-Directed Case Management, Homemaker, Medical Adult Day Care, Transportation, RN Assessment and Review and for Personal Options members, Participant-Directed Goods and Services.

Personal Options information has been incorporated into the section above.

501.6.1 INFORMAL SUPPORTS

Inherent in the ADW Program is the provision of medically necessary health and social services utilizing both formal and informal supports. Informal supports include family members, relatives, friends, neighbors, or any community volunteers who are willing to commit themselves to provide certain tasks for a member. Although informal supports are not a mandatory requirement for participation in the ADW Program, most members will need a combination of informal and formal supports to meet their needs in the community. Examples of members who may need stable informal supports are those who are:

A. Unable to transfer independently.
B. Confused, combative, or incoherent, such as with dementia or Alzheimer's.

C. Unable to administer medications.
D. Unable to call for assistance.
E. Unable to be left alone safely.
F. Potentially at risk, due to deterioration in medical condition or deterioration in environment that, in the absence of additional support, could result in harm or injury.
G. Exposed to harm or injury that can be attributed to deterioration and lack of support. For example, member becomes anemic, dehydrated, or malnourished due to an inability to obtain food and/or fluids.

The above information on informal supports also applies to Personal Options.

501.7 COVERED SERVICES

Except for the limitation and exclusions listed below, BMS will pay for the following medically necessary and medically appropriate ADW services provided to eligible Medicaid members by ADW Program provider agencies.

501.7.1 CASE MANAGEMENT CODE, UNIT, LIMIT AND DOCUMENTATION REQUIREMENTS

Procedure Code: G9002
Service Unit: All CM services provided within one month
Service Limit: Reimbursed at a monthly rate
Prior Authorization Available: No
Documentation Requirements: All contacts with, or on behalf of, a member must be documented within the member's record, including date and time of contact, description of contact, and signature of CM. CM Assessment and SCP must be complete (Attachments 4 & 5).

Case Management activities are indirect services that assist the member in obtaining access to needed services. These include, but are not limited to, social, educational, health, and medical care services. If consistent with the policy requirements for documentation, the full monthly case rate can be billed for a member who has received ADW services at any time during the month. The monthly case rate encompasses all case management services that are needed by the member.

501.7.1.1 CASE MANAGEMENT

Case management includes the coordination of services that are individually planned and arranged for members whose needs may be life-long. The practice of case management helps to avoid duplication and provision of unnecessary services, and to ensure a balance of services. The CM takes an active role in service delivery; although services are not provided directly by the CMA, the CM serves as an advocate and coordinator of care for the member. This involves collaboration with the ADW member, family members, friends, informal supports, and health

care and social service providers. The following principles are given as a guide to the case management approach to long-term care:

A. Social, environmental, service, and support needs are evaluated.
B. An individualized SCP (Attachment 5) is developed and written as needed and details all services that are to be provided. The CM is to coordinate the delivery of care, eliminate fragmentation of services, and assure appropriate use of resources.
C. The SCP includes both formal and informal (if available) services that assist the member to achieve optimum function.
D. The CM proactively identifies problems and coordinates services that provide appropriate high quality care to meet the individualized and often complex needs of the member.

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501.7.1.2 STAFF CASELOADS, QUALIFICATIONS, AND TRAINING

Each provider must assure that there is an adequate number of qualified staff for the number of members served. A CM must be licensed in West Virginia as a Social Worker, Counselor, or Registered Nurse. A full-time-equivalent CM can serve no more than seventy-five (75) members; a six-month average can be used. All documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality agreements (see Common Chapter 100, ¶ 191), and references shall be maintained on file by the provider. The provider shall have a review process to ensure that employees providing ADW services meet the minimum qualifications.

501.7.1.3 SCREENING

Once an applicant's medical eligibility determination for ADW services has been made by the QIO and the applicant has returned the Freedom of Choice Case Management Selection Form, the CMA that has been selected by the applicant or BoSS (as is the case when the applicant indicates "No Choice" on the CMA selection form) will be notified, and a copy of the Pre-Admission Screening Form (PAS) (Attachment 14) will be provided. (When the applicant chooses the consumer-directed option, BoSS will be notified; see ¶501.7.2 for more information about Consumer-Directed Case Management.) Within three (3) working days of receipt of this notification, the CM must make an initial contact by telephone or face-to-face with the applicant. The CM must submit a DHS-2 form (Attachment 1) to the county DHHR office to determine financial eligibility based on ADW criteria. A copy of the "Eligibility Determination" page of the PAS must be attached to the DHS-2 form. Financial eligibility cannot be initiated without both documents. (See ¶501.3.6 for more information about financial eligibility.)

501.7.1.4 ASSESSMENT

Assessment is an essential function of the case management process. It is an organized multidimensional process by which the CM collects and analyzes in-depth information about the member's environment, socialization activities, and services and social support received.

Once the individual has been found eligible for the ADW program (both medical and financial eligibility have been determined), the CM will schedule a visit within seven (7) working days to complete the Case Management Assessment (Attachment 4). At this time, the CM will provide the member with the Freedom of Choice Homemaker Selection Form. Homemaker Selection Forms are available on BoSS' Web site at www.state.wv.us/seniorservices.

A comprehensive assessment includes a review of the following:

A. Need for nursing care;
B. Need for social services;
C. Physical, social, and mental functioning status;
D. Home environment and informal supports, if available;
E. Potential risks to health and welfare; and
F. Identified problems/risks.
G. Back up emergency plan

501.7.1.5 CARE PLANNING

Care planning is the process by which the CM develops a member-centered, evidence-based, interdisciplinary SCP (Attachment 5) based on the assessment process outlined in ¶501.7.1.4. The CM will coordinate with the HMA that the member has selected. Once the HMA has agreed to accept the member, the PAS will be forwarded by the CMA to the HMA. The CM arranges the SCP meeting and collaborates with the HM RN; Medical Adult Day Care, if appropriate; the member; and the informal support(s), if available, to develop an individualized SCP. It is mandatory that the CM, HM RN, and member attend the SCP meeting. The informal(s) may wish to attend the meeting either in person or by telephone. Other service providers may participate in person or by telephone. The SCP meeting must be scheduled within fourteen (14) working days of the Case Management Assessment.
The SCP must detail all services the member is receiving and problems/risks identified in the Case Management Assessment. Once the SCP is developed and implemented, follow-up and monitoring are required as described in ¶501.7.1.6 All problems noted on the SCP must have outcome codes assigned. (Refer to Attachment 5). Continuing contact among the CMA and other providers ensures that services are being delivered in accordance with the SCP. Documented notes of these contacts are placed by the CM in the member's file for review by BoSS monitoring staff.

501.7.1.6 CASE REVIEW

The CM is responsible for follow-up with the member to ensure that services are being provided as described in the SCP. Initial contact must be made a minimum of seven (7) working days or maximum of fourteen (14) working days after direct care services have begun by the HMA. A monthly telephone contact and a six-month face-to-face contact with the member are required to assure that the member is receiving services in accordance with the SCP, to identify any new problems, and to evaluate outcomes of current problems noted on SCP. If the member cannot be reached by telephone for the monthly contact, a home visit must be made. (Sample Member Contact Form or Sample Recording Log may be used; see Attachments 6 and 7.)

Specific activities to assure that needs are being met also include:

A. Assure financial eligibility remains current.

B. Assure safety and welfare of the member.
C. Address changing member needs as reported by the HM RN, member, or informal support.
D. Address changing needs determined by the monthly member contact.
E. Refer and procure any additional services the member may need that are not services the HM can provide, such as hospice and home health.
F. Annually, or more often as necessary, coordinate with all current service providers to review and revise the SCP. An SCP meeting must be held with the annual assessment.
G. Submit the updated SCP to all applicable service providers that are providing services to the member.
H. Submit Medical Necessity Evaluation Request (Attachment 15) to QIO annually (see ¶501.3.4).

501.7.1.7 ADVOCACY

As an advocate, the CM supports the member in meeting goals and ensures that those involved in caring for the member understand the member's individualized needs. The CM ensures that member's/member representative's wishes and preferences are reflected in the development of service and support plans by working directly with the member/member representative and all service providers. Case management advocacy refers to the actions undertaken on behalf of the member in order to ensure continuity of services, system flexibility, integrated services, proper utilization of facilities and resources, and accessibility to services. It also assures that the member's legal and human rights are protected. The CM must also ensure that a signed and current Informed Consent & Release of Information (Attachment 8) is on file. The QIO will have this form signed by the applicant/member during both the initial medical evaluation and the medical reevaluation process and will send it to the CMA. For more information about member privacy see Common Chapter 300, ¶320.6.

501.7.1.8 REPORTING

The CMA will complete and submit required administrative and program reports or reports as requested by either BMS or BoSS. The BoSS reports include the Case Management Agency Monthly Report, Case Closure Report, New Case Open Report, Medicaid Client Information Form, and Agency Monthly Incident Tracking Report (Attachment 18).

501.7.2 CONSUMER-DIRECTED CASE MANAGEMENT

The Consumer-Directed Case Management service gives members and/or their representatives the authority to develop service and support plans that reflect their wishes and preferences by working directly with the HMA and other providers for the provision of services. Individuals who choose Consumer-Directed Case Management do so with the knowledge that they must meet

specific requirements and with the knowledge that they receive no Medicaid reimbursement for this activity.

Once medical eligibility has been established, the applicant is notified by the QIO and provided with a Freedom of Choice Case Management Selection Form. The applicant chooses CM services to be provided by either a CMA or through the Consumer-Directed Case Management option. If the consumer-directed option is chosen, BoSS is notified by the QIO. BoSS then mails the applicant a DHS-2 form with the "Eligibility Determination" page of the PAS, a Medicaid Client Information Form, a Representative Form, a Freedom of Choice Homemaker Selection Form, and a Service Coordination Plan.

The applicant/applicant's representative must take the DHS-2 form and the "Eligibility Determination" page of the PAS to the county DHHR office for financial eligibility assessment. If financially approved, the member completes the Medicaid Client Information Form, the Representative Form, the Homemaker Selection Form, and the SCP, and returns them to BoSS. The SCP must detail all services the member is receiving, and it must be completed every twelve (12) months or as needed if a member's condition changes. The member then makes contact with the HMA he/she has selected. The HMA will complete an assessment and develop a Homemaker POC based on the member's needs.

The consumer-directed case manager must ensure continued financial eligibility is maintained with DHHR or the SSA if the member receives SSI, ensure that continued medical eligibility is maintained by submitting an annual Medical Necessity Evaluation Request to the QIO, coordinate for durable medical equipment and other services if necessary, and coordinate and schedule any skilled services needed by the member.

501.7.3 HOMEMAKER

Homemaker services are defined as long-term direct care and support services that are necessary in order to enable an individual to remain at home rather than enter a NF, or to enable an individual to return home from a NF.

Homemaker services provide eligible members with trained workers who perform health maintenance services, such as assisting with ambulation/exercises, prompting with normally self-administered medications, reporting changes in the member's condition and needs, and/or providing household services essential to maintaining the member in the home. Homemaker services include assistance with personal hygiene, nutritional support, and environmental maintenance.

All of the above homemaker information also applies to Personal Options.

501.7.3.1 HOMEMAKER - STAFF QUALIFICATIONS AND TRAINING

All documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality statements (Attachment 13), and references shall be maintained on file by the provider A HM RN must have a current West Virginia RN license. Homemaker direct care staff must have met all training requirements as described in ¶501.7.8 ¶501.7.8.1, and ¶501.7.9. The provider shall have a review process to ensure that employees providing ADW services meet the minimum qualifications as outlined in this section. The agency must provide direct care staff copies of documentation of all training provided.

In Personal Options, all documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality statements (Attachment 13A), and references shall be maintained on file by the F/EA-RC.

A HM RN must have a current West Virginia RN license. Homemaker direct care staff must have met all training requirements as described in ¶501.7.8 ¶501.7.8.1, and ¶501.7.9. The F/EA-RC shall have a review process to ensure that employees providing ADW services meet the minimum qualifications as outlined in this section. The F/EA-RC must provide direct care staff copies of documentation of all training provided.

501.7.3.2 HOMEMAKER RN RESPONSIBILITIES: INITIAL ASSESSMENT AND ANNUAL REVIEW

Procedure Code: T1001
Modifier: UD
Service Limits: 1 event per calendar year (January - December)
Prior Authorization Available: No
Documentation Requirements: All contacts with, or on behalf of, a member must be documented within the member's record, including date with beginning and ending time, description of contact, and signature of HM RN. RN Assessment and Plan of Care must be complete.

Activities included in this event are:

A. Home visit;
B. Complete RN assessment (Attachment 9);
C. Development of POC; and
D. Participation in the SCP meeting.

All of these activities must be completed prior to the submission of claims for services provided.

501.7.4 MONTHLY RN SERVICES

Procedure Code: T1002
Modifier: UD
Service Unit: 15 minutes
Service Level: 6 units per month
Prior Authorization Available: No
Documentation Requirements: All contacts with, or on behalf of, a member must be documented within the member's record, including date with beginning and ending time, description of contact, and signature of HM RN. RN Assessment and Plan of Care must be complete.

Functions that **are billable** include:

A. Attend other meetings in addition to the initial assessment and SCP meeting, including the service planning meeting involved in a request for dual provision of ADW and Personal Care services (see ¶501.7.12).
B. Make a home visit with the member and HM within thirty (30) days after HM services begin.
C. Complete nursing reassessment and update POC every six (6) months; this must be a face-to-face assessment. Exception: More frequent assessments may be required if the member's needs or medical conditions change; documentation must substantiate the need for additional assessments. RN Assessment (Attachment 9) or Member Contact Form/Recording Log (see Attachments 6 and 7 for samples) may be used as condition warrants.
D. Review and sign the HM worksheets (Attachment 11) to assure services were provided as described in the POC and that member's initials and signature are appropriate.
E. Upon notification that a member has been discharged from an acute care hospital, NF, or other residential setting, complete a nursing assessment to determine the need for changes in the POC, and notify the CMA if additional services or changes in services are needed. The completion of a post-hospital visit and RN Assessment form is based on the professional judgment of the agency RN.
F. Compile, prepare, and submit material that can be used to assess an ADW member's need for additional HM hours. Additional hours can only be requested for members at Level of Care A, B, or C, and only when there is a substantial change in the member's medical condition. In order to determine whether additional hours are warranted, a completed Request for Level of Care Change (Attachment 12) must be submitted to BMS. Clinical documentation sufficient to support the request must be submitted, which may include applicable test results from a member's physician or

hospital discharge summary. These documents must be on the letterhead of the physician and/or hospital and dated no later than one month prior to, or one month following, the request for an increased level of care. Information that will not be considered includes any verbal or telephonic statements; or letters from family, neighbors, friends, or case management and homemaker staff without attached physician's documentation or discharge summary. The Request must be signed by both the ADW RN and the member. Original signatures are required; i.e., "signature of member on file" is not acceptable. A LOC determination will then be established by a BMS RN. This request may or may not result in a change in the LOC. Notice of this determination will be sent to the member and the HMA. The HMA must notify the appropriate CMA (or member/member representative in the case of Consumer-Directed Case Management) of the result of this process.

Please note: Members who are appealing a **denial** of medical eligibility will remain at their current level of care pending a fair hearing decision. BMS will not review a request for an increased level of care for such members.

Functions that are considered to be administrative duties and **are not billable** include:

A. Determine if the agency can accept the member based on the number of direct care staff available. Assure that direct care HM services will be in place in the member's home within seven (7) working days from the date of the SCP meeting.
B. Send copies of any changes in the POC to the CMA or member representative.
C. Notify the CMA if a member has been admitted to or discharged from an acute care hospital, NF, or other residential facility.
D. Establish criteria and methodology for evaluating the overall job performance of each HM providing ADW services. The HM RN is responsible for performance evaluation of non-licensed direct care staff. Evaluation outcomes of staff should be used to develop continuing education for all staff or those individuals with skill deficits.
E. Complete and submit required administrative and program reports or reports as requested by either BMS or BoSS, including Homemaker Agency Monthly Report and Agency Monthly Incident Tracking Report (Attachment 18), as necessary.
F. Maintain emergency back-up plan for member's care in the event the HM is unable to fulfill duties.
G. Develop notification method for members to utilize after hours.
H. Be available to the homemaker for consultation and assistance at any time when the homemaker is providing services.
I. Telephone calls.

501.7.5 HOMEMAKER FUNCTIONS

Procedure Code: S5130
Service Unit: 15 minute**s**
Service Limits: Determined by Levels of Care Criteria and Levels of Care Service Limits (See ¶501.3.2.1 and ¶ 501.3.2.2).
Prior Authorization Available: Yes, for Levels A, B, and C only; Request for Level of Care Change (Attachment 12) must be approved by BMS RN.

The functions of the HM include providing direct care services as defined by the member's POC, recording member's progress and communicating to RN, accurately recording time spent with the member, and participating in in-service training as required by the ADW Program.

HM duties and responsibilities as described in the POC may include:

A. Assist member with environmental tasks necessary to maintain the member in the home.
B. Assist member with Activities of Daily Living (ADLs).
C. Assist member with completion of errands that are essential for the member to remain in the home—grocery shopping, medical appointments and outpatient medical treatments, and trips to the pharmacy. The member may accompany the HM on these errands.
D. Assist member in community activities. These activities may not exceed twenty (20) hours per month within the allocated hours determined by the LOC. Activities provided in the community should be determined by the member, CMA, and HMA at the SCP meeting. Community activities must be documented on the POC. Priority within the POC should be given to direct care services before the inclusion of community activities. Prior authorization of additional units of HM services will not be available to provide community activities.
E. Prepare meal(s) for member.
F. Report significant changes in member's condition to the RN, including incident reporting (see ¶501.2.2).
G. Assist member with transferring from bed to chair or wheelchair.
H. Assist with ambulation.
I. Prompt for self-administration of medications.
J. Maintain records as instructed by the RN.
K. Perform other duties as assigned by RN within program guidelines.
L. Accurately complete HM worksheet and other records as instructed by the RN.

501.7.6 MEMBER TRANSPORTATION BY HOMEMAKER

Procedure Code: A0160
Service Unit: 1 unit - 1 mile

Service Limit: N/A
Prior Authorization: No

The member may be transported by the HM in order to gain access to services and activities as specified in the POC. Family, neighbors, friends, or community agencies that can provide this service, without charge, must be utilized first. Mileage can be charged for both essential errands (see ¶501.7.5 #C)-, activities related to the SCP and community activities (see ¶501.7.5 #D).

501.7.7 FUNCTIONS OR TASKS NOT TO BE PERFORMED BY THE HOMEMAKER

A member's physician may prescribe services that can only be performed by a licensed health professional, not a HM. The CMA has the responsibility of referring the member to an agency that provides such services. A member may receive services from home health, a personal care agency, and/or a provider agency of the ADW Program as long as there is no duplication of provided services.

Homemakers may not perform any service that is considered to be a professional skilled service, including, but not limited to, the following:

A. Care or change of sterile dressings.
B. Care of colostomy irrigation.
C. Gastric lavage or gavage.
D. Application of heat in any form.
E. Care of tracheostomy tube.
F. Suctioning.
G. Vaginal irrigation.
H. Give injections, including insulin.
I. Any personal care not included on the member's POC or RMP for Personal Options.
J. Administer any medications, prescribed or over-the-counter.
K. Perform catheterizations, apply external (condom type) catheter.
L. Tube feedings of any kind.
M. Make judgments or give advice on medical or nursing questions.

If at any time a HM is witnessed to be, or suspected of, performing any prohibited tasks by any staff working for a HMA, CMA, BMS, BoSS, the F/EA-RC or the QIO, the HM RN or F/EA-RC must be notified immediately. The HM must receive immediate verbal instructions to discontinue performing such tasks for the member. If a HM continues to perform any of the prohibited tasks, the HMA will be deemed out of compliance with program standards, and risks sanctions. Failure to comply could result in billing adjustments.

Personal Options information has been incorporated into the section above.

501.7.8 HOMEMAKER BASIC TRAINING REQUIREMENTS

Each provider agency shall have an approved basic training curriculum that prepares non-licensed staff for direct care and service provision. Provider agencies must make available to direct care staff copies of their training records. Copies of training records and certifications must be shared with employees and a copy maintained in employees' personnel files.

New non-licensed direct care staff who have no training or experience must receive eight (8) hours of basic training before rendering care or unsupervised service to an eligible member. Within twelve (12) months of the beginning date of employment, new staff must receive at least twenty-four (24) hours of additional training, for a total of thirty-two (32) hours. The initial eight-hour training must cover the following areas; areas marked with an asterisk (*) are mandatory training areas and cannot be substituted:

A. *Orientation to the agency, community, and services, including responsibilities regarding reporting changes in the member's condition and needs.
B. Working with specific populations including the elderly, persons with behavioral disorders, and distinct categories of physical or cognitive disabilities.
C. Body Mechanics.
D. *Personal Care skills including, but not limited to, bathing, grooming, feeding, toileting, transferring, positioning, ambulation, range of motion, and vital signs. (A Physician's Order is required in addition to this training before non-licensed direct care staff can take vital signs or perform range of motion.)
E. Care of the home and personal belongings.
F. *Accident prevention and safety.
G. Food, nutrition, and meal preparation.
H. *Occupational Safety and Health Administration (OSHA) standards related to blood-borne pathogens, Cardiopulmonary Resuscitation (CPR), and First Aid Training. First Aid training may be provided by a qualified HM RN; First Aid does not have to be a certified course.
I. *Adult Abuse, Neglect, and Exploitation.
J. *Confidentiality laws and regulations (HIPAA).

501.7.8.1 SUBSTITUTION OF BASIC TRAINING REQUIREMENTS

The mandatory components in ¶501.7.8 may not be waived. However, the other requirements for basic training for non-licensed direct care staff may be waived if one of the following substitution requirements are met:

A. Documentation of successful completion of one of the following related training courses: certified nurse aide, home health aide, and homemaker aide or other

institutional or home-based skill course that has been reviewed and approved as comparable by licensed personnel of the provider agency. Documentation of completion by the training course provider will be maintained in personnel records.

B. One year of experience providing direct care in-home services with the type of population being served by the provider. Verification of this requirement will be met through written reference checks and kept in the personnel file.

501.7.9 ANNUAL IN-SERVICE TRAINING REQUIREMENTS

In addition to basic training, each HM must complete eight (8) hours of annual in-service training. This training must be documented. In planning the in-service training, providers shall consider the following:

A. Each homemaker providing ADW services is provided with additional training to develop specialized skills or to review and enhance skills learned in basic training.
B. On-the-job training shall be provided as needed to instruct the homemaker in specific skills or techniques for individual members.
C. Assistance in resolving problems in particular case situations may also be used as a training opportunity.
D. OSHA; First Aid; and Adult Abuse, Neglect, and Exploitation training must be kept current. "Current" is defined as completed within the last 12 calendar months; CPR, is current as defined by the American Heart Association or the American Red Cross.

501.7.10 MEDICAL ADULT DAY CARE

Medical Adult Day Care (MADC) services may be offered to members of the ADW Program. If available in member's area, MADC should be discussed as a possible service during the SCP meeting.

MADC is designed to be an alternative to institutional services by providing members with routine health and maintenance care combined with daily structured and supportive activities in a congregate daytime setting. MADC centers are regulated by the WV Office of Health Facility Licensure and Certification.

The MADC center will complete and submit required administrative and program reports as requested by either BMS or BoSS.

Procedure Code: S5101
Service Unit: ½ day (minimum 4 hours)
Service Limit: 25 days in one month
Prior Authorization Available: No
Procedure Code: S5102

Service Unit: 1 day (minimum 7 hours)
Service Limit: 25 days in one month
Prior Authorization Available: No

Personal Options: Members who select Personal Options cannot self-direct Medical Adult Day Care Services but they can access these services through a provider.

501.7.11 PERSONAL OPTIONS CODE, UNIT, LIMIT AND DOCUMENTATION REQUIREMENTS

Procedure Code: T1015 U1- Level A: T1015U2- Level B: T1015 U3- Level C: T1015 U4- Level D
Provider may bill the encounter code for the appropriate level of care, which is all inclusive of G9002 Case Management, T1001 UD Homemaker RN Initial Assessment and Annual Review, T1002 UD Monthly RN Services, S5130 Homemaker Services, and A0160 Transportation. Provider must itemize the specific code, of services provided under the encounter on the claim.
Service Unit: All ADW Personal Options Services provided in one month.
Service Limit: Reimbursed as specified on the individualized spending plan not to exceed monthly rate.
Prior Authorization Available: Yes, Procedure Code Based on level of care A, B, C, or D.

G9002 Case Management
Case management: Case Management includes the coordination of services that are individually planned and arranged for members whose needs may be life-long. The practice of case management helps to avoid duplication and provision of unnecessary services, and to ensure a balance of services. The CM takes an active role in service delivery; although services are not provided directly by the CMA, the CM serves as an advocate and coordinator of care for the member. This involves collaboration with the ADW member, family members, friends, informal supports, and health care and social service providers. The following principles are given as a guide to the case management approach to long-term care:

A. Social, environmental, service, and support needs are evaluated.
B. An individualized RMP is developed and written as needed and details all services that are to be provided. The CM is to coordinate the delivery of care, eliminate fragmentation of services, and assure appropriate use of resources.
C. The RMP includes both formal and informal (if available) services that assist the member to achieve optimum function.
D. The CM proactively identifies problems and coordinates services that provide appropriate high quality care to meet the individualized and often complex needs of the member.

Qualifications: A CM must be licensed in West Virginia as a Social Worker, Counselor, or Registered Nurse. All documented evidence of staff qualifications such as licenses,

transcripts, certificates, signed confidentiality agreements (see Common Chapter 100, ¶ 191), and references shall be maintained on file by the Fiscal Employer Agent.

Assessment: Assessment is an essential function of the case management process. It is an organized multidimensional process by which the CM collects and analyzes in-depth information about the member's environment, socialization activities, and services and social support received.

A comprehensive assessment may include a review of the following:

A. Need for nursing care
B. Need for social services
C. Physical, social, and mental functioning status
D. Home environment and informal supports, if available
E. Potential risks to health and welfare
F. Identified problems/risks

Care Planning: Care planning is the process by which the CM develops a member-centered, evidence-based interdisciplinary RMP and Spending Plan based on the individuals needs and assessments. The RMP must detail all services the member is receiving.

Case Review: The CM is responsible for working with the member to ensure that services are being provided as described in the RMP.

Specific activities a member may request their CM perform to assure that needs are being met include:

A. Assure financial eligibility remains current.
B. Assure safety and welfare of the member.
C. Address changing member needs as reported by member and/or representative, staff, or informal supports.
D. Address changing needs determined by member contact.
E. Refer and procure any additional services the member may need, such as hospice and home health.
F. Annually, or more often as necessary, coordinate with the member and all current service providers to review and revise the RMP.
G. Submit the updated RMP to all applicable service providers that are providing services to the member.
H. Submit Medical Necessity Evaluation Request (Attachment 15) to QIO annually (see ¶501.3.4).

Advocacy: As an advocate, the CM supports the member in meeting goals and ensures that those involved in caring for the member understand the member's individualized needs. The CM ensures that member's/member representative's wishes and preferences are reflected in the development of the RMP by working directly with the member/member representative and all service providers. Case management advocacy refers to the actions undertaken on behalf of the member in order to ensure continuity of services, system flexibility, integrated services, proper utilization of facilities and resources, and accessibility to services. It also assures that the member's legal and human rights are protected. In Personal Options, the F/EA-RC must ensure that a signed and current Informed Consent & Release of Information (Attachment 8) is on file. The QIO will have this form signed by the applicant/member during both the initial medical evaluation and the medical reevaluation process and will send it to the F/EA-RC. For more information about member privacy see Common Chapter 300, ¶320.6.

Documentation Requirements: All contacts with, or on behalf of, a member must be documented within the member's record, including date and time of contact, description of contact, and signature of CM. Resource Management Plan and Spending Plan must be complete.

Case Management activities are indirect services that assist the member in obtaining access to needed services. These include, but are not limited to, social, educational, health, and medical care services. If consistent with the policy requirements for documentation, the full individualized budget amount as specified on the spending plan can be billed for a member who has received ADW services at any time during the month.

T1001 UD HOMEMAKER RN RESPONSIBILITIES: INITIAL ASSESSMENT AND ANNUAL REVIEW

Documentation Requirements: All contacts with, or on behalf of a member must be documented within the member's record, including date with beginning and ending time, description of contact, and signature of HM RN. RN Assessment must be complete.
Activities included in this event are:

A. Home visit
B. Complete RN assessment (Attachment 9)
C. Participation in the RMP meeting
D. Participation in the development of the RMP and Spending Plan

All of these activities must be completed prior to the submission of claims for services provided.

S5130 HOMEMAKER FUNCTIONS

The functions of the HM include providing direct care services as defined by the member's RMP recording member's progress, accurately recording time spent with the member, and participating in training as required by the ADW Program.

Perform health maintenance service, such as assisting with ambulation/exercises, prompting with normally self-administered medications. Reporting change in the member's conditions and needs and/or providing household services essential to maintaining the member in the home. Homemaker services include assistance with personal hygiene, nutritional support, community activities and environmental maintenance.

T1002UD Monthly RN Services

Documentation Requirements: All contacts with, or on behalf of, a member must be documented within the member's record, including date with beginning and ending time, description of contact, and signature of HM RN.

Functions of a HM RN are to perform Homemaker RN services requested by the member including homemaker training and assistance with the development of Resource Management Plan. A HM RN also assures maintenance and implementation of the Resource Management Plan. If a member requires a request for a level of care change, the HM RN will assist in this process.

A0160 Member Transportation by Homemaker

The member may be transported by the HM in order to gain access to services and activities as specified in the RMP. Family, neighbors, friends, or community agencies that can provide this service, without charge, must be utilized first. Mileage can be charged for essential errands, activities related to the RMP, and community activities.

501.7.12 PERSONAL OPTIONS PARTICIPANT-DIRECTED GOODS AND SERVICES

Procedure Code: **T2028**
Service Unit: As specified on RMP
Service Limit: $1000 Annually
Prior Authorization Available: Yes

Services, equipment or supplies not otherwise provided through the Medicaid State Plan that address an identified need in the Resource Management Plan, decrease the need for other Medicaid services and/or increase the person's safety in the home environment. The member must budget for their approved good or service within their allocated budget. The following are non-allowable services, equipment or supplies: gifts for workers/family/friends, payments to someone to serve as a representative, clothing, food and beverages, electronic entertainment equipment, utility payments, swimming pools and spas, costs associated with travel, comforters,

linens, drapes, furniture, vehicle expenses including routine maintenance and repairs, insurance and gas money, medications, vitamins, herbal supplements, monthly internet service, printers, yard work, illegal drugs or alcohol, household cleaning supplies, respite services, spa services, education, personal hygiene, adult day care and discretionary cash. All participant-directed goods and services must be approved by the Bureau of Senior Services.

501.7.13 PERSONAL OPTIONS BASIC TRAINING REQUIRMENTS

Personal Options direct care staff who have no training or experience must receive eight (8) hours of basic training before rendering care or unsupervised service to an eligible member. Within twelve (12) months of the beginning date of employment, new staff must receive at least twenty-four (24) hours of additional training, for a total of thirty-two (32) hours. The initial eight-hour training must cover the following areas; areas marked with an asterisk (*) are mandatory training areas and cannot be substituted:

A. *Orientation to the F/EA-RC Agency, community, and services, including responsibilities regarding reporting changes in the member's condition and needs.
B. Working with specific populations including the elderly, persons with behavioral disorders, and distinct categories of physical or cognitive disabilities.
C. Body Mechanics.
D. *Personal Care skills including, but not limited to, bathing, grooming, feeding, toileting, transferring, positioning, ambulation, range of motion, and vital signs. (A Physician's Order is required in addition to this training before non-licensed direct care staff can take vital signs or perform range of motion.)
E. Care of the home and personal belongings.
F. *Accident prevention and safety.
G. Food, nutrition, and meal preparation.
H. *Occupational Safety and Health Administration (OSHA) standards related to blood-borne pathogens, Cardiopulmonary Resuscitation (CPR), and First Aid Training. First Aid training may be provided by a qualified HM RN; First Aid does not have to be a certified course.
I. *Adult Abuse, Neglect, and Exploitation.
J. *Confidentiality laws and regulations (HIPAA).

Members and their direct care staff may access a F/EA-RC-Resource Consultant for training materials and assistance. Copies of training records and certifications will be maintained in the F/EA-RC files.

501.7.13.1 PERSONAL OPTIONS SUBSTITUTION OF BASIC TRAINING REQUIREMENTS

The mandatory components in ¶501.7.8.2 may not be waived. However, the other requirements for basic training for non-licensed direct care staff may be waived if one of the following substitution requirements are met:

A. Documentation of successful completion of one of the following related training courses: certified nurse aide, home health aide, and homemaker aide or other institutional or home-based skill course that has been reviewed and approved as comparable by the F/EA-RC. Documentation of completion by the training course provider will be maintained in F/EA-RC records.
B. One year of experience providing direct care in-home services with the type of population being served by the provider. Verification of this requirement will be met through written reference checks and kept in the F/EA-RC records.

501.7.13.2 PERSONAL OPTIONS ON-GOING ANNUAL TRAINING

Members may require their direct care staff to have additional training to meet the member's specific needs.

501.7.14 AGENCIES PROVIDING BOTH HOMEMAKER AND CASE MANAGEMENT SERVICES

Case management and homemaker services can be provided by the same agency within the counties in which approval has been granted by BoSS. However, each service must have it's own staff, for example, an agency Registered Nurse may not provide both HM and CM services for the same member. Members are to be offered freedom of choice of provider for services. Conflicts of interest and self-referral are prohibited.

Not applicable to Personal Options.

501.7.15 DUAL PROVISION OF ADW AND PERSONAL CARE (PC) SERVICES (For Personal Options refer to 507.15.1)

Approval of the provision of both ADW and PC services to the same person will be considered if the following criteria are met:

A. Any PC services provided to an active ADW member must be approved by the reviewing agencies (see #H below), including the initial 60 hours. "Dual Service Provision Request" (Attachment 19) must be completed.
B. An ADW member must be receiving services at Level of Care D. (Otherwise, additional hours of HM services may be requested through a Request for Level of Care Change (Attachment 12).
C. All policy set forth in Chapter 517 of the Personal Care Manual must be followed.

PC policy supercedes ADW policy for this request.

D. There must be a PC RN Plan of Care and a HM RN Plan of Care. Both plans must be coordinated between the two agencies providing hands-on direct services to ensure that services are not duplicated. PC and HM services cannot be provided during the same hours on the same day. A service planning meeting between the Case Manager (ADW agency or self-directed), HM RN, and PC RN must be held with the member in the member's residence and documented on the "Request for Dual Service Provision."
E. There must be a valid ADW PAS and a valid PC Medical Eligibility Assessment that documents the need for both services.
F. The ADW CM or self-directed CM will be responsible for the coordination of the two services. If there is no CMA (member is self-directed), the ADW RN and the PC RN will provide oversight to assure compliance.
G. Permission to provide PC and ADW services to a member must be requested by the PC RN and signed by the PC RN, CM (or responsible party if self-directed), HM RN, and the member or member's representative. Original signatures are required; i.e., "signature of member on file" is not acceptable.
H. Senior Centers PC providers should submit requests to:

West Virginia Bureau of Senior Services
State Capitol
1900 Kanawha Blvd., East
Charleston, West Virginia 25305
Fax: 304 558-6647

All other PC providers should submit requests to:

West Virginia Bureau for Medical Services
Aged and Disabled Waiver Program
350 Capitol Street, Room 251
Charleston, West Virginia 25301
Fax: 304 558-1509

I. Documentation submitted must include approved current medical eligibility of both ADW and PC services, ADW and PC RN Plans of Care, RN assessments, and any documentation that substantiates the request. Additionally, a narrative describing how services will be utilized and verification that ADW and PC services will not be duplicated must be submitted, as well as documentation of caregivers for both programs and their relationship to the member. Requests will be reviewed by BoSS or BMS RNs. Approvals/denials will be based on the documentation submitted, appropriate program policy manuals, PC standards, and professional judgments. The member or member's representative, PC RN, HM RN, and CM will receive

notification of denial or approval from the reviewing agency. If the request is denied or the hours approved are less than requested, the notification will include fair hearing information.

J. BMS will conduct post-payment review of these combined services for duplication or inappropriate services. BoSS and BMS will review compliance during the agency monitoring process.

501.7.15.1 PERSONAL OPTIONS DUAL PROVISION OF ADW AND PERSONAL CARE (PC) SERVICES

Approval of the provision of both ADW and PC services to the same person will be considered if the following criteria are met:

A. Any PC services provided to an active ADW member must be approved by the reviewing agencies (see #H below), including the initial 60 hours. "Dual Service Provision Request" (Attachment 19A) must be completed.
B. An ADW member must be receiving services at Level of Care D. (Otherwise, additional hours of HM services may be requested through a Request for Level of Care Change (Attachment 12A).
C. All policy set forth in Chapter 517 of the PC Manual must be followed. PC policy supercedes ADW policy for this request.
D. There must be a PC RN Plan of Care and Resource Management Plan. Both plans must be coordinated, providing hands-on direct services to ensure that services are not duplicated. PC and HM services cannot be provided during the same hours on the same day. A planning meeting must be held with the member and documented on the "Request for Dual Service Provision."
E. There must be a valid ADW PAS and a valid PC Medical Eligibility Assessment that documents the need for both services.
F. The member or their representative will be responsible for the coordination of the two services. If there is no Case manager, the PC RN will provide oversight to assure compliance.
G. Permission to provide PC and ADW services to a member must be requested by the PC RN and signed by the PC RN and the member or their representative. Original signatures are required; i.e., "signature of member on file" is not acceptable.
H. Senior Centers PC providers should submit requests to:

   West Virginia Bureau of Senior Services
   State Capitol
   1900 Kanawha Blvd., East
   Charleston, West Virginia 25305
   Fax: 304 558-6647

All other PC providers should submit requests to:

West Virginia Bureau for Medical Services
Aged and Disabled Waiver Program
350 Capitol Street, Room 251
Charleston, West Virginia 25301
Fax: 304 558-1509

I. Documentation submitted must include approved current medical eligibility of both ADW and PC services, RMP and PC RN Plans of Care, and any documentation that further substantiates the request. Additionally, a narrative describing how services will be utilized and verification that ADW and PC services will not be duplicated must be submitted. Requests will be reviewed by BoSS or BMS RNs. Approvals/denials will be based on the documentation submitted, appropriate program policy manuals, PC standards, and professional judgments. The member or member's representative, PC RN, HM RN (if applicable), and CM (if applicable) will receive notification of denial or approval from the reviewing agency. If the request is denied or the hours approved are less than requested, the notification will include fair hearing information.

J BMS will conduct post-payment review of these combined services for duplication or inappropriate services. BoSS and BMS will review compliance during the monitoring process.

501.8 ADDITIONAL SERVICES: PRIVATE PAY

Private Pay Services are those services that are not covered by the ADW program. A member may desire additional services that are not within the scope of the ADW Program. If the family or other support systems are unable to provide these services, they may be purchased by the member and/or family from any source, including an ADW provider agency. This additional care is referred to as private pay.

The member's Service Coordination Plan (SCP) or Resource Management Plan (Personal Options) must contain reference to any other service(s) received by the member, regardless of the source of payment. An ADW agency that provides private-pay services to a member must ensure that documentation is maintained separately.

Personal Options information is incorporated into the section above.

501.9 SERVICE OPTIONS AND LIMITATIONS

Homemaker service is a required service for the ADW program. Medical Adult Day Care is an optional service. Case Management is also an optional service, as a member may choose Consumer-Directed Case Management or Personal Options. Homemaker is not an optional

service. A member in the ADW Program must receive homemaker services to remain eligible for the program. Homemaker services are limited to a maximum number of hours or monthly budget for Personal Options, that is determined by the member's Level of Care (LOC). The notification of medical eligibility from the QIO will specify the maximum hours a member may receive in a month. If it is believed that the member's LOC has changed, the Homemaker RN or member in Personal Options must submit a Request for Level of Care Change (Attachment 12 or Attachment 12A for Personal Options) to the Bureau for Medical Services. (See ¶501.7.4 #F, Billable Functions, for information about this procedure.)

Personal Options information is incorporated into the section above

501.10 EXCLUDED SERVICES AND NON-REIMBURSABLE SITUATIONS

Medicaid will only reimburse agencies for ADW services that are defined as required services on the member's SCP or RMP (See Common Chapter 300 for more information about reimbursement.) The following services are not reimbursable:

A. ADW services are not intended to provide supervision or 24-hour care. ADW services (reimbursable by Medicaid) are to be provided exclusively to the member, for necessary activities as listed in the POC and SCP and RMP; they are not to be provided for the convenience of the household or others. Although informal supports are not mandatory in the ADW Program, the program is designed to provide formal support services to supplement, rather than replace, the member's existing informal support system.
B. Services provided for another member(s) of the ADW member's household or any other who is not an ADW Program member.
C. Services provided by a CMA, HMA, or MADC that are not included in the SCP, POC or RMP have not received prior authorization.
D. Services provided to an individual who is not medically and financially eligible on the date(s) that service is provided.

Personal Options information is incorporated into the section above.

501.11 DIRECT CARE PROVIDER RESTRICTIONS

Medicaid prohibits the spouse of an ADW member from providing ADW services for purposes of reimbursement.

The above information on Direct Care Provider Restrictions also applies to Personal Options.

501.12 MONITORING FOR QUALITY ASSURANCE BY BoSS

Chapter 501-Covered Services, Limitations, and Exclusions for Aged and Disabled Waiver Services

Monitoring of ADW service providers and the F/EA-RC will be completed by BoSS on a regular basis. Site visits will be done every twelve (12) to twenty-four (24) months; more frequent visits will be completed if a need is indicated. Each site of a provider agency will be reviewed individually. Appointments will be scheduled with the provider or the F/EA-RC as a courtesy but this is not mandatory. Unscheduled visits may be made as the need arises, and any information requested, including member and agency information, must be made available upon demand.

Monitoring will include a minimum of a 10% sample of the member caseload (or 10 case files) and a minimum of 10% of the personnel files. Monitoring tools, developed in conjunction with the BMS Office of Quality and Program Integrity (OQPI), will be utilized. (Monitoring tools are available on BoSS' Web site at www.state.wv.us/seniorservices.) Monitoring may include reviewing the PAS, assessments, SCP, POC, and RMP including spending plan (for Personal Options) log notes, HM worksheets, billing records, personnel files, and agency site reviews, and home visits with members. In some instances a full review of all records will be conducted.

Completed reports will be made available to the provider agency or the F/EA-RC within sixty (60) days of the review. Response to any corrective action will be expected within sixty (60) days after receipt of the completed report. Sanctions will be imposed as findings dictate.

Personal Options has been incorporated into this section.

CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 1
DHS-2
REFERRAL FORM FOR MEDICAID
AGED & DISABLED WAIVER PROGRAM
PAGE 1 OF 2

WV Department of Health and Human Resources
Referral Form for Medicaid Aged and Disabled Waiver Program

DATE: _____

TO: _____, Income Maintenance Worker

FROM:_____
Case Management Agency or WV Bureau of Senior Services

Address _____Phone: _____

Applicant
Name_____

Address_____

Phone_____County_____SSN: _____

_____has been medically approved for the Medicaid Aged and Disabled Waiver Program. The cost of services and the medical determination substantiate the need for the long-term care services that will be provided.

Please determine this person's financial eligibility for the Medicaid Aged and Disabled Waiver Program and return one copy of this completed form to the applicant and one copy to the Case Management Agency or WV Bureau of Senior Services, as applicable.

_____ _____
Case Manager Date

Economic Service Worker Response

_____ (Name) is financially eligible for this program.

YES:_____ Effective Date:_____ Medicaid #:_____
NO:_____

_____ _____
Economic Service Worker Date

Terminal Operator

Case Number_____

_____ _____
Date Transmitted Terminal Operator

Send 1copy CMA or BoSS; 1 File Copy
DHS-2.FRM 8/06

CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 1A
DHS-2
PERSONAL OPTIONS REFERRAL FORM FOR
MEDICAID AGED & DISABLED WAIVER PROGRAM
PAGE 1 OF 2

WV Department of Health and Human Resources
Referral Form for Medicaid Aged and Disabled Waiver Program - Personal Options

---

Date: _____

To: _____, Income Maintenance Worker

DHHR Office Address: _____

FROM:_____
WV Bureau of Senior Services

Address _____Phone: _____

Applicant
Name_____

Address_____

Phone_____County_____SSN: _____

_____has been medically approved for the Medicaid Aged and Disabled Waiver Program and has chosen Personal Options. The cost of services and the medical determination substantiate the need for the long-term care services that will be provided.

Please determine this person's financial eligibility for the Medicaid Aged and Disabled Waiver Program and return one copy of this completed form to the applicant and one copy to the Fiscal/Employer Agent.

_____ _____
Bureau of Senior Services Date

Economic Service Worker Response

_____ (Name) is financially eligible for this program.

YES:_____ Effective Date:_____ Medicaid #:_____
NO:_____

_____ _____
Economic Service Worker Date

Terminal Operator

Case Number_____

_____ _____
Date Transmitted Terminal Operator

Send 1copy to the Bureau of Senior Services, 1900 Kanawha Blvd. East, Charleston, WV 25305
Send 1 copy to the applicant
Personal Options DHS-2 FRM 11/06

CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 2
MEMBER REQUEST TO TRANSFER FROM ONE HOMEMAKER AGENCY OR CASE MANAGEMENT AGENCY TO ANOTHER

West Virginia Medicaid Aged and Disabled Waiver Program

MEMBER REQUEST TO TRANSFER FROM ONE HOMEMAKER AGENCY OR CASE MANAGEMENT AGENCY TO ANOTHER

Name:_____

Street Address: _____

City:_____ Zip Code: _____ County: _____

Telephone Number: _____

Level of Care (Hours of Service Per Month), if known:
_____

Contact Person, if other than Member:
_____

Contact Person Telephone Number:_____

I, _____, request to transfer from

_____,

my current Homemaker or Case Management agency (please circle one of these). The reason I

want to transfer is _____

_____

I understand that I will be contacted by a staff member from the Bureau of Senior Services for an explanation of the transfer process and my freedom of choice options. I understand that my request for transfer will be acted upon within 45 days from the receipt of this form by the Bureau of Senior Services. I understand that my transfer will become effective on the first day of a month, which begins a new billing period for the agencies that are providing my services.

_____
Member or Representative Signature

_____
Date

Return Address
Bureau of Senior Services
1900 Kanawha Blvd. East
Charleston, WV 25305
Phone: (304) 558-3317
Fax: (304) 558-6647

CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 2A
PERSONAL OPTIONS
TRANSFER FORM
PAGE 1 OF 2

West Virginia Medicaid Aged and Disabled Waiver Program

Personal Options Transfer Form

Name: _____

Street Address:_____

City: _____ Zip Code: _____ County: _____

Telephone Number: _____

Level of Care (Hours of Service Per Month), if known: _____

Representative (if applicable): _____

Telephone Number: _____

Legal Guardian (if applicable): _____

Telephone Number (if applicable): _____

I, _____ request to transfer from _____ to _____. The reason I want to transfer is_____.

I understand that I will be contacted by a staff member from the Bureau of Senior Services for an explanation of the transfer process and my freedom of choice options. I understand that my request for transfer will be acted upon within 45 days from the receipt of this form by the Bureau of Senior Services. I understand that my transfer will become effective on the first day of a month, which begins a new billing period for my services.

Member Signature	Date
Representative Signature (if applicable)	Date
Legal Guardian Signature (if applicable)	Date

Return Address
Bureau of Senior Services
1900 Kanawha Blvd. East
Charleston, WV 25305
Phone: (304) 558-3317
Fax: (304) 558-6647

CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 3
MEMBER GRIEVANCE FORM
PAGE 1 OF 3

West Virginia Medicaid Aged and Disabled Waiver Program

MEMBER GRIEVANCE FORM

Date:_____

Name:_____

Address:_____

Telephone Number:_____

Contact Person, if other than Member:_____

Contact Person Telephone Number:_____

Statement of Complaint:_____

_____

_____

_____

Relief Sought:_____

_____

_____

Level One - Meeting of ADW Service Provider Agency Director (or Designee) and Member

Date of Meeting _____ Telephone or Face-to-Face (Circle One)

Decision/Action Taken:_____

_____

_____

Date of Decision_____

Member to Check (√) One of the Following:

_____ I am satisfied with the Level One Decision.

_____ I am not satisfied with the Level One Decision and wish to move to Level Two.

_____
Member Signature

_____
Provider Agency Director or Designee

_____
Date

Level Two - Referral of Grievance to the WV Bureau of Senior Services

Date of Discussion with Member and ADW Service Provider:

_____

Date of Decision: _____

Decision/Action Taken: _____

_____

_____

Date Member Notified of Decision: _____

_____
Bureau of Senior Services Representative

8/06

CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 3A
PERSONAL OPTIONS MEMBER GRIEVANCE FORM

This form is to be used when a member is dissatisfied with the F/EA-RC. Level 1 should be directed to the F/ED-RC. If member is not satisfied with Level 1 decision, form should be sent to BoSS for Level 2 resolution.

West Virginia Medicaid Aged and Disabled Waiver Program
Personal Options
MEMBER GRIEVANCE FORM

Date:_____

Name: _____

Address: _____

Telephone Number: _____

Representative (if applicable) _____

Telephone Number: _____

Statement of Complaint:

_____
_____
_____
_____

Relief Sought

_____
_____
_____
_____

LEVEL ONE - Meeting of Resource Consultant and/or Fiscal Management Entity and Member

Date of Meeting _____

Decision/Action Taken:

_____
_____
_____

Date of Decision _____

___ I am satisfied with the Level One Decision

___ I am not satisfied with the Level One Decision and wish to move to Level Two

_____
Member Signature

_____
Provider Agency Director or Designee

_____
Date

LEVEL TWO – Referral of grievance to the West Virginia Bureau of Senior Services

Date of Meeting/Discussion _____

Date of Decision _____

Decision/Action Taken:

_____
_____
_____
_____

_____ _____
Bureau of Senior Services Representative Date

11/06

CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 4
CASE MANAGEMENT ASSESSMENT
PAGE 1 OF 14

INSTRUCTIONS

Must be completed initially and annually and updated at least every 6 months. If member's situation changes, a new assessment may be needed. Must be filled out completely; leave no blank spaces. Must be signed and dated by Case Manager completing assessment.

West Virginia Medicaid Aged and Disabled Waiver Program
CASE MANAGEMENT ASSESSMENT (8/06)

Date of Assessment: **Financial Eligibility Effective Date:**

Annual Review Date: **6-Month Review Date:**

6-Month Review Completed:

A. IDENTIFYING INFORMATION

Name: _____ Male ____ Female ____

Address: _____ County_____ Phone_____

Date of Birth: _____/_____/_____ Marital Status: Married___ Single___ Widowed___

Divorced___

Diagnosis: Primary _____ Secondary _____

Allergies: _____

Directions to Member's Home (attach additional page if needed):

_____

Health Insurance Information:

Medicaid #: **Other Health Insurance:**

Medicare Part A #: **Medicare Part B #:** **Eff. Date:**
Medicare Part D#: **PDP Name:** **Member's PDP ID #:**

List those present at this assessment:

Name	Relationship/Profession

Responsible Person(s), Advance Directives:

Legal Guardian ___	Medical PoA ___	Durable PoA ___	DNR ___	POST ___
Committee ___	PoA ___	Conservator ___	Living Will ___	

Representative(s):

Name:	Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone:	Phone:

Informal Support:

Name:	Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone:	Phone:

Attending/Personal Physician(s):

Name:	Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone:	Phone:

B. ENVIRONMENTAL ASSESSMENT

General Information:

Location:	Urban _____	Rural _____	Other _____
Type of Home: *(Please check all that apply)*	Apartment _____	Duplex _____	Single Family _____
	Multi-Family _____	Single Story _____	Two-Story _____
	Ground Floor _____	Isolated _____	Other _____

Own _____	Rent _____	Live with a relative or a friend _____	Government Subsidized _____

Household Composition:

Member resides with		
	Name	Relationship
Member resides with		
	Name	Relationship
Member resides with		
	Name	Relationship
Member resides with		
	Name	Relationship

C. SELF PRESERVATION SKILLS

Ability to use phone

Operates on own initiative	_____	Dials well-known numbers	_____
Answers phone only	_____	Unable to use phone	_____
Assisted by: _____			

Additional Comments:

_____

_____

Finances

Manages independently, pays bills, goes to the bank	_____
Manages ordinary purchases, but has trouble balancing checkbook or paying bills	_____
Sometimes needs help for simple purchases, unable to pay bills	_____
Incapable of handling money matters	_____
Assisted by: _____	

Additional Comments:

_____

_____

Transportation

Drives self, able to travel independently	_____
Can drive, travel on own, but afraid and unwilling	_____
Public transportation available	
Must be driven, but can travel	_____
Does not travel	_____
Assisted by: _____	

Additional Comments:

_____

_____

D. SOCIALIZATION

1. On the average, how often do you talk to your friends and relatives who do not live with you, either by visiting or phone?		
Daily _____	1 - 6 times a week _____	2 -3 times a month _____
Monthly or less _____	Rarely _____	Never _____

2. How often do you leave your home?		
Daily _____	1 - 6 times a week _____	2 -3 times a month _____
Monthly or less _____	Rarely _____	Never _____

3a. How do you spend your days?

3b. What activities do you enjoy?

3c. Are there activities you would like to do but have not been able to?

4. Have you lost anyone near to you in the past five years? Is there anything else in the past five years that upset you very much? Check all that apply.	
Loss of spouse _____	Loss of caregiver (other than spouse) _____
Other loss (specify) _____	Traumatic injury _____
Traumatic illness _____	Relocation _____
Loss of residence _____	Other (specify) _____
Comments:	

E. SERVICES AND SOCIAL SUPPORT

1. How much help per week is member receiving from his/her informal network of family/friends?	
None _____	Occasional _____
Several times weekly _____	Daily (1-2 hours per day) _____
More than 2 hours per day, but not constant _____	Constant _____

2. Who is primarily providing that help?		
Daughter _____	Other relatives _____	Help paid by member _____
Son _____	Friends _____	Help paid by relative _____
Spouse _____		

3. Is the member's informal network of family and friends able to continue giving help at this current level of need?		
Yes ____	No ___	Probably ___

4. Does the member's informal network of family and friends seem to be sufficiently capable of responding to an increased demand for services in the case of illness or accident?		
Yes ___	No ___	Probably ___

5. List the informal supports currently giving assistance to the member. (Do not list those who are noted in Section A, page 2.)

Name	Relationship	Address	Phone

E. SERVICES AND SOCIAL SUPPORT, cont.

6. List the formal agencies currently providing services in the home.			
Agency	Contact Person	Service	Frequency

F. POTENTIAL RISKS TO HEALTH AND WELFARE

IDENTIFIED HIGH RISK FACTORS	**YES**	**NO**	**COMMENTS**
Smoking			
Obesity			
Alcohol Dependency			
Drug Dependency			
Other:			
ENVIRONMENTAL			
Heat			
Air Conditioning			
Working Cooking Stove			
Working Refrigerator			
Telephone Access			
Feels Safe in Home			
Feels Safe in Neighborhood			
Emergency System Contact			
Excessive/Harmful Animals in Home			
Smoke Alarm			
Carbon Monoxide Alarm			
Other:			

F. POTENTIAL RISKS TO HEALTH AND WELFARE, cont.

FALL RISKS (Check all that apply.)

- ☐ Scattered Floor Rugs
- ☐ Uneven Flooring
- ☐ Unsteady Gait
- ☐ Outside/Inside Stairs
- ☐ Use of ambulation equipment
- ☐ Grab Bars in Bathroom
- ☐ Other: _____
- ☐ None of the above

NEURO/EMOTIONAL/BEHAVIORAL STATUS (Check all that apply.)

Member's Cognitive Functioning:

- ☐ Alert/oriented
- ☐ Requires prompting such as cueing and reminders some of the time.
- ☐ Requires prompting such as cueing and reminders all of the time.
- ☐ Requires considerable assistance in routine situations. Is not alert and oriented.
- ☐ Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

When confused (reported or observed):

- ☐ Never
- ☐ In new or complex situations only
- ☐ On awakening or at night only
- ☐ Constantly
- ☐ Patient non-responsive

When Anxious (reported or observed):

- ☐ None of the time
- ☐ Less often than daily
- ☐ Daily, but not constantly
- ☐ All of the time
- ☐ Patient non-responsive

Behavioral Symptoms:

- ☐ Wandering
- ☐ Verbally abusive
- ☐ Physically abusive
- ☐ Socially inappropriate/disruptive
- ☐ Resists care
- ☐ Change in behavioral symptoms compared to last Case Management Assessment

F. POTENTIAL RISKS TO HEALTH AND WELFARE, cont.

NEURO/EMOTIONAL/BEHAVIORAL STATUS, cont.

Indicators of Depression:

 Negative statements – i.e., "Nothing matters. I would rather be dead. What's the use? I regret having lived so long. Let me die."
 Repetitive questions – i.e., "Where do I go? What do I do?"
 Repetitive verbalizations – i.e., calling out for help ("God help me.")
 Persistent anger with self or others
 Self deprecation – i.e., "I am nothing. I am of no use to anyone."
 Expressions of what appear to be unrealistic fears – i.e., fear of being abandoned, left alone, being with others
 Recurrent statements that something terrible is about to happen – i.e., about to die, have a heart attack
 Repetitive health complaints
 Repetitive anxious complaints/concerns (non-health related)
 Sleep cycle issues
 Sad, apathetic, anxious appearance, especially facial
 Crying, tearfulness, hand-wringing, restlessness
 Loss of interest, withdrawn from activities of interest, reduced social interaction

ORAL/NUTRITIONAL STATUS

Oral Problems

 Chewing
 Swallowing
 Pain
 None of the above

Oral Status and Disease Prevention

 Has dentures or removable bridge
 Some/all natural teeth lost – does not have or does not use dentures or partial plates
 Broken, loose, or carious teeth
 None of the above

Height/Weight

Height _____
Weight _____

Weight Change

 Weight loss – 5% or more in last 30 days or 10% or more in last 180 days
 Weight gain – 5% or more in last 30 days or 10% or more in last 180 days

Nutritional Problems

 Complains about the taste of many foods
 Regular or repetitive complaints of hunger
 Leaves 25% or more of food uneaten at most meals
 None of the above

F. POTENTIAL RISKS TO HEALTH AND WELFARE, cont.

Nutritional Approaches (check all that apply in last 7 days):

- ☐ Parenteral/IV
- ☐ Feeding Tube
- ☐ Mechanically Altered Diet
- ☐ Syringe (oral feeding)
- ☐ Therapeutic diet
- ☐ Dietary supplement between meals
- ☐ On planned weight change program
- ☐ None of the above

COMMUNICATING/HEARING PATTERNS

Hearing (with hearing appliance if used)

- ☐ Hears adequately – normal talk, TV volume
- ☐ Minimal difficulty
- ☐ Hears in special situations only – speaker has to adjust volume and speak distinctly
- ☐ Highly impaired – absence of useful hearing

Communication Devices/Techniques (check all that apply during the last 7 days)

- ☐ Hearing aid, present and used
- ☐ Hearing aid, present and not used regularly
- ☐ Other receptive communication techniques used (i.e., lip reading)
- ☐ None of the above

Modes of Expression (check all used by resident to make needs known)

- ☐ Speech
- ☐ Writing messages
- ☐ American Sign Language or Braille
- ☐ Signs, gestures, sounds
- ☐ Communication board
- ☐ Other
- ☐ None of the above

Making Self Understood

- ☐ Understood
- ☐ Usually understood – difficulty finding words or finishing thoughts
- ☐ Sometime understood – ability is limited to making concrete requests
- ☐ Rarely/Never understood

Speech Clarity

- ☐ Clear speech
- ☐ Unclear speech
- ☐ No speech

F. POTENTIAL RISKS TO HEALTH AND WELFARE, cont.

Ability to Understand Others

- ☐ Understands
- ☐ Usually understands
- ☐ Sometimes understands
- ☐ Rarely/Never understands

Changes in Communication/Hearing - Ability to express, understand, or hear information has changed as compared to last Case Management Assessment:

- ☐ No change
- ☐ Improved
- ☐ Deteriorated

SKIN CONDITION

Ulcers

- ☐ **Pressure**
- ☐ **Stasis**
- ☐ **N/A**

History of Unresolved Ulcers

- ☐ **Yes**
- ☐ **No**

Other Skin Problems or Lesions Present (check all that apply during last 7 days)

- ☐ **Abrasions, bruises**
- ☐ **Burns**
- ☐ **Open lesions other than ulcers, cuts, rashes**
- ☐ **Rashes**
- ☐ **Skin desensitized to pain or pressure**
- ☐ **Surgical wounds**
- ☐ **None of these**

Skin Treatments (check all that apply during last 7 days)

- ☐ Pressure relieving device(s) for chair
- ☐ Pressure relieving device(s) for bed
- ☐ Turning/repositioning program
- ☐ Nutrition or hydration intervention to manage skin problems
- ☐ Ulcer care
- ☐ Surgical wound care
- ☐ Application of dressings (with or without topical medications) other than to feet
- ☐ Application of ointments/medications other than to feet
- ☐ Other preventative or protective skin care other than to feet
- ☐ None of the above

Foot Problems and Care (check all that apply during the last 7 days)

- ☐ **One or more foot problems – i.e., corns, calluses**
- ☐ **Infection of the foot – i.e., cellulitis, purulent drainage**
- ☐ **Open lesions on the foot**
- ☐ **Nails/calluses trimmed during last 90 days**
- ☐ **Received preventative or protective foot care – i.e., special shoes, inserts, pads, toe separators**
- ☐ **Application of dressings (with or without medications)**
- ☐ **Regular Visits to Podiatrist**
- ☐ **None of these**

F. POTENTIAL RISKS TO HEALTH AND WELFARE, cont.

RESPIRATORY STATUS

Is the member ever short of breath?

- ☐ Yes
- ☐ No

Respiratory Treatments Utilized at Home: (mark all that apply)

- ☐ Oxygen (intermittent or continuous)
- ☐ Ventilator
- ☐ Positive Airway Pressure (C-Pap or Bi-Pap)
- ☐ Nebulizer Treatments
- ☐ None of the above

SUMMARY of POTENTIAL RISKS TO HEALTH AND WELFARE

PROBLEMS/RISKS IDENTIFIED	NOTE IF ADDRESSED IN SCP
Identified High Risk Factors	
Self-Preservation Skills	
Environmental	
Fall Risks	
Neuro/Emotional/Behavioral Status	
Socialization/Social Support	
Oral/Nutritional Status	
Communication/Hearing Patterns	
Skin Condition	
Foot Problems	
Other Identified Problems	

G. EMERGENCY BACK-UP PLAN

7. Describe in detail the member's back-up plan if the Homemaker would be/is unable to fulfill duties (use back of page if necessary).

INFORMATION ON ASSESSMENT PROVIDED BY:

Member provided all answers: _____

Member provided some answers: _____

Informal provided some answers: _____

Informal provided all answers: _____

_____ _____

Member's Signature **Date**

H. PROBLEMS/RISKS IDENTIFIED AND RECOMMENDATIONS
All problems/risks identified and recommendations must be addressed on the member's Service Coordination Plan (SCP).

1. Summarize the assessment findings completed upon home visit, listing all problems/risks identified (use back of page if necessary).

2. What are the Case Manager's recommendations?

_____ _____ _____

Case Manager **Title** **Date**

CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 5
SERVICE COORDINATION PLAN
PAGE 1 OF 3

INSTRUCTIONS

Must be completed initially and annually and updated at least every 6 months. Must update with any change in member's situation. All services provided to member must be listed. All identified problems/risks must be addressed. Must be filled out completely, no blank spaces. Signatures and date required initially and annually for Case Manager, Homemaker RN and member during Service Coordination Plan (SCP) meeting. Six-month signatures required for Case Manager and member. Homemaker may sign if applicable.

West Virginia Medicaid Aged and Disabled Waiver Program
SERVICE COORDINATION PLAN

Member Name	Medicaid #	Period of Plan	Reevaluation Date

County	Level of Care/Hours Per Month	Date SCP Completed

Physician	Diagnosis(es)

Service	Agency	Provider/Contact	Phone	Begin & End Dates	Frequency Days-Hours	Outcome Code 6 mo.	Outcome Code Year
CASE MANAGEMENT							
HOMEMAKER							
INFORMAL							

APPROVAL SIGNATURE		DATE	APPROVAL SIGNATURE		DATE
MEMBER			**CASE MANAGER**		
6-month			6-month		
INFORMAL			**HOMEMAKER RN**		
6-month			6-month		

OUTCOME CODES	
Delivered/Ongoing	Q
Delivered with Changes	R
Not Delivered	S
Discontinued	T
Resolved	U-Z

8/06

SERVICE COORDINATION PLAN, cont.

Member Name	Medicaid #	Period of Plan	Reevaluation Date

Identified Problems/ Risks as noted in Case Management Assessment	Service(s) to Address Problems/Risks	Provider	Contact	Phone	Begin & End Dates	Frequency Days- Hours	Outcome Code 6 mo.	Year

8/06

CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 6
SAMPLE MEMBER CONTACT FORM
PAGE 1 OF 2

INSTRUCTIONS

This is a sample to be used if desired. If used, must be filled in completely; leave no blank space; use N/A if necessary. Must be signed and dated by Case Manager or the HM RN completing form.

SAMPLE MEMBER CONTACT FORM

Member: _____ DOB: __ __/__ __/__ __

Contact: Home Visit ____ Telephone Call: ____ Other: _____

Reason for Contact: _____

General Health Status: _____

Vital Signs: BP _____ Resp. _____ Pulse _____ Temp. _____ Ht. _____ Wt. _____

Any changes in Functional Status: _____

_____

Adequate Support System: Yes ____ No ____

Who Assists Member When Homemaker Not Available? _____

Are Homemakers Providing Appropriate Care: Yes ____ No ____ Document: _____

_____

_____

SCP/POC Reviewed to Assure Member's Need Being Met: Yes ____ No ____

Actions Taken to Revise SCP/POC if Needed: _____

_____

Update Drug Profile Sheet if Needed: Yes ____ No ____

CM or HM RN Signature: _____

Date: _____

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CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 7
SAMPLE RECORDING LOG
PAGE 1 OF 2

INSTRUCTIONS

This is a sample to be used if desired. If used, must be filled in completely; leave no blank spaces; u se N/A if necessary. Must be signed and dated by Case Manager or HM RN completing form.

West Virginia Medicaid Aged and Disabled Waiver Program

SAMPLE RECORDING LOG

MEMBER: _____ **MEDICAID #** :_____

Date:	Contact: ☐Telephone ☐Member ☐Informal ☐Correspondence ☐Other (specify): Location: ☐Home ☐Office ☐Hospital ☐Program ☐Other (specify):
Min.:	Purpose:
Miles:	

Activity: Content - what happened/details

Outcome Plan

CM or HM RN Signature: _____

Date: _____

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CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 8
AGENCY AND PERSONAL OPTIONS
INFORMED CONSENT & RELEASE OF INFORMATION
PAGE 1 OF 2

WEST VIRGINIA MEDICAID AGED AND DISABLED WAIVER PROGRAM
INFORMED CONSENT AND RELEASE OF INFORMATION

I understand that I may meet the criteria for either nursing home placement or participation in the Aged and Disabled Waiver Program (A/D Waiver). If eligible, I have a choice of either service. By signing this form, I have chosen to be evaluated for the A/D Waiver instead of the nursing home placement. I have been provided a fact sheet about the A/D Waiver and Estate Recovery and have had the opportunity to discuss services and ask questions based on this information. I also understand that I have the choice of two service delivery models within the waiver program. In the traditional agency option, I understand that I have the freedom of choice between qualified providers and services that will meet my needs based on the Service Coordination Plan.

In Personal Options (the self-directed option), I understand that I have the freedom to choose my own providers and services that will meet my needs based on the Resource Management Plan and my own spending plan.

Based On this information, I hereby:

1. Request an assessment for the evaluation of my health status in order to determine appropriate services to be provided that meet my needs.

2. Understand that A/D Waiver staff and/or contracted entities through the Bureau for Medical Services will interview my physician(s), involved family members, friends and other professionals involved in my case.

3. Authorize A/D Waiver staff and/or contracted entities through the Bureau for Medical Services to obtain medical records and health related information from health care and social service professionals involved in my case.

4. Authorize A/D Waiver staff to release my Service Coordination Plan (traditional agency option) or Resource Management Plan (self-directed option) which describes all services received by me. This information can be released to all agencies and individuals involved in my care, and, at my request, family members, neighbors, and other volunteers (only on a need-to-know basis). Otherwise, records will be kept confidential and released only to authorized agencies as provided by West Virginia and Federal Law. I understand that program information (without personal identification) may be used in research and analysis to evaluate performance to improve services.

5. Understand that the service I receive through the A/D Waiver may not be sufficient to meet all my care needs and that I may need support for the times waiver services are not available.

6. Understand that I have the right to access the toll-free number, 1-866-767-1575, to voice questions, concerns, or complaints about the A/D Waiver Program.

7. Understand that I have the right to withdraw from the program by informing A/D Waiver staff in writing. I further understand that if I choose to withdraw from the program, my Medicaid card will be terminated if I qualified for the program based on the 300% special income level.

_____ _____

Member Signature Date

_____ _____

Representative Signature (if applicable) Date

_____ _____

Legal Guardian Signature (if applicable) Date

_____ _____

Interviewer/Witness Signature Date

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ATTACHMENT 9
RN ASSESSMENT FORM & DRUG PROFILE SHEET

INSTRUCTIONS

Must be completed initially and annually and updated at least every 6 months. If member condition changes (for example, hospital or NF discharge), an updated assessment may be needed. Must be filled out completely; leave no blank spaces; use N/A if necessary. Must be signed and dated by RN completing assessment. Assessments must be face-to-face. Must keep drug profile current.

West Virginia Medicaid Aged and Disabled Waiver Program
RN ASSESSMENT

MEMBER: _____ DOB: _____ DATE: _____

Current Diagnosis: _____
Past Medical History: _____

Vital Signs		ALLERGIES:_____	Last Physician Visit:
BP	____ /___	_____	_____
PULSE	____	Adm. to Acute Care Facility in past year?	Physician:
RESP	____	YES _____ NO _____	_____
TEMP	____	Reason: _____	Reason: _____
WT	____	_____	_____
HT	____		_____

	PHYSICIAN(S)	SPECIALTY	PHONE NUMBER
1			( ) -
2			( ) -
3			( ) -
4			( ) -

	INFORMAL SUPPORT	RELATIONSHIP	PHONE NUMBER
1			( ) -
2			( ) -
3			( ) ____ -

RESOURCES AVAILABLE TO MEMBER				RISK FACTORS		
Home-Delivered Meals	Yes	No		Obesity	Yes	No
Med. Adult Day Care	Yes	No		Smoker	Yes	No
Other (list):	Yes	No		Alcohol	Yes	No
				Drugs	Yes	No

SPECIAL SERVICE NEEDS: (DESCRIBE B/B PROGRAM, R.O.M., ROUTINE WOUND CARE, ETC.)
_____

_____
PROFESSIONAL SERVICE NEEDS: (DESCRIBE ANY SKILLED SERVICE) _____

_____

CIRCLE ASSISTIVE DEVICES IN HOME: WALKER/ CANE/ CRUTCHES/ HOSPITAL BED/ BEDSIDE COMMODE/ SHOWER CHAIR-BENCH/ WHEELCHAIR/ LIFTCHAIR/ EGGCRATE/ HOYER LIFT/ TRAPEZE/ GLUCOMETER/OTHER:

RATE FUNCTIONAL STATUS: I = INDEPENDENT A = ASSIST S = SUPERVISE T = TOTAL

TOILETING		GROOMING		ENVIRONMENTAL	
BATHING		DRESSING		MEDICATION ASSISTANCE	
TRANSFERRING		AMBULATION		MEAL PREPARATION	
EATING					

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RN ASSESSMENT, cont.

MEMBER: _____ DATE: _____

NEURO:	A&O X _____ / Disoriented ____ EXPLAIN: Vision: WNL's / Glasses / Contacts / Implants / Blind L / R / Drops OS-OU-OD / Cataracts Hearing: WNL's / HOH / Requires Repeats / Aids L / R / Deaf L / R / Implants
MUSCU:	Posture: Upright / Bent Forward /Scoliosis Gait: Steady / Unsteady Strength: Upper Extremity L____ R ____ Assistance: 1 person / 2 person / total Lower Extremity L ____ R ____ ROM Deficits Sensation: Pain / Numbness / Tingling / Site:
CARDIO:	Discomfort: Y / N Palpitations: Y / N Pacemaker: Y / N Date Inserted:
RESP:	R_____ L_____ Non-labored / Labored - Rest / Activity Cough: Y / N Sputum: Y / N Consistency: Thick / Thin Color: White / Tan / Yellow / Pink / Bloody / Green / Clear Equipment: Oxygen ____ L / Min. 24hrs. / HS / PRN / Neb's / Inhalers / Bi-Pap / C-Pap / IS
GI:	Appetite: Very good / good / fair / poor Ensure / Vitamins / Herbs / Supplements Diet: Regular / AHA / ADA / 1200 / 1500 / 1800 / 2000 / Low fat / Low NA / Low Cholesterol Special restrictions: Teeth: Natural Set / Caries / Edentulous / Dentures: Upper / Lower / Partial / U/L / Bridge U/L Bowels: Regular / Diarrhea / Constipated / Enemas / Laxatives / Fiber: tabs / food / mixes Continence: Total Incontinence: Total / Partial Protection: Pads / Diapers / Shields / Pull-Ups
GU:	Kidneys: WNL's / Urgency / Burning / Pain / Dribbling Urine: Foul Odor / Discolored Continence: Total Incontinence: Total / Partial Protection: Pads / Diapers / Shields / Pull-Ups Fluid Intake per Day: H2O ___ 8 oz. glass(es) Caffeine: coffee / tea / soda(s) ___ cups Juice ____ cups
SKIN INTEGRITY:	Warm / Dry / Moist / Clammy Pink / Pallor / Erythema / Jaundice / Cyanotic / Rash Peripheral Edema 0+ 1+ 2+ 3+ 4+ Pitting / Non-Pitting / Weeping / Bruised Breakdown: NA / Location: _____ Stage 1 2 3 4

Comments:

_____

_____

_____

_____

_____

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MEMBER: _____ DATE: _____

Next MD Appt.:	Time:	Physician:		
Homemaker Review	Satisfactory	Unsatisfactory	Comment:	
Drug Profile	Unchanged	Changed	New	See Attached
Plan of Care Reviewed with Member: Yes _____ No _____		Informal: Yes _____ No _____ N/A _____		

INITIAL VISIT _____
6 MONTH _____
ANNUAL _____ RN Signature:
_____

EXTRA VISIT _____
POST HOSPITAL _____ Date:
_____

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West Virginia Medicaid Aged and Disabled Waiver Program

DRUG PROFILE SHEET

Member:_____ Date of Birth: ___ ___/ ___ ___/ ___ ___ ___ ___

Diagnosis:_____ Allergies:_____

_____ _____

_____ _____

_____ _____

Pharmacy: _____ Primary Physician: _____

Date Reviewed	New (N) Change (C) Discontinued (DC)	Medication	Prescription	Ordering Physician	Additional Information and Instructions

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AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 10
PLAN OF CARE
PAGE 1 OF 3

INSTRUCTIONS

Plan of Care must be completed initially and annually and updated at least every 6 months in conjunction with mandatory assessments. It should reflect member's current Level of Care and must be justified. (For example, POC shows Monday-Thursday, 4 hours/day and Friday 5 hours/day, the need for the additional hour on Friday must be documented.)

Update with any change in member status. Plan period must include date (M/D/Y) of start and finish of POC. Show time approved daily (i.e., 4 hours) and expected arrival and end time. Must be signed and dated by RN completing POC. Add any specific orders in "Comments". "Description of Service Care—Circle Level of Assistance" will reflect member's current LOC, mark only one. Address any variation in "Comments".

West Virginia Medicaid Aged and Disabled Waiver Program

PLAN OF CARE

Member Name: _____ Plan Period: _____

Medicaid Number: _____ Level of Care:____ Nurse Signature/Date: _____

Day of the Week																	
Time Approved - Daily																	
Time to Arrive																	
Time to Leave																	

DESCRIPTION OF SERVICE CARE - CIRCLE LEVEL OF ASSISTANCE (Circle Only One)

Bath: Sponge/Tub/Shower (Total/Assist/ Supervise/Independent)																	
Skin Care: Lotion/Shaving/Catheter Care																	
Hair (Total/Assist/Supervise/Independent)																	
Nails: Trim/File DO NOT TRIM NAILS OF DIABETIC																	
Mouth Care: Dentures/Own Teeth/Oral Care/ (Total/Assist/Supervise/Independent)																	
Dressing (Total/Assist/Supervise/ Independent)																	
Ambulation: Walk/Cane/Walker/Wheelchair (Total/Assist/Supervise/Independent)																	
Transfer (Total/Assist/Supervise/ Independent)																	
Toileting: Bathroom/Bedpan/ Bedside Commode/Incontinent/Empty Catheter Bag/Empty Ostomy Appliance (Total/Assist/ Supervise/ Independent)																	
Positioning: Turn Every ____hr(s) Up in Chair																	
Bedmaking: Hospital Bed/Regular Bed																	
Special Directions: Unsterile Dressings/Ice Pack/Elevate Feet/Other_____																	
Assist with Medication: (Assist/Prompt/ Independent)																	
Meals: Breakfast/Lunch/Dinner Diet: _____																	
Essential Errands: 1X Week/PRN X1, 2, 3 (grocery, pharmacy, medical appts.)																	
Laundry: Laundromat/In-Home/Apartment Complex																	
Transportation																	
Community Activities (not to exceed 20 hours/mo.)																	

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ENVIRONMENTAL

Vacuum/Sweep																	
Mop																	
Dust																	
Straighten																	
Other: _____																	

TREATMENTS PER PHYSICIAN'S ORDER

Temperature																	
Pulse																	
Respiration																	
Blood Pressure																	
Range of Motion																	
Other: _____																	

COMMENTS

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CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 11
HOMEMAKER WORKSHEET
PAGE 1 OF 3

INSTRUCTIONS

Homemaker Worksheet may be used weekly or bi-weekly at agency discretion.

Plan period must include date (M/D/Y) or start and finish of HMWS.

Must show date of service, time arriving, time leaving, and total time worked during day.

"Description of Service Care—Circle Level of Assistance" will reflect member's current LOC; mark only one. Address any variation in "Comments."

Mileage block must be completed with any mileage billed and/or time used to transport member. Show date of trip, total mileage, destination (i.e., grocery store, doctor's appointment, visit neighbor), and total time used.

Homemaker must initial each service completed daily, and member must initial each day to verify services received.

Homemaker needs to document any problem or reason for change in POC in comments section. At end of HMWS plan period, Homemaker and member must sign and date that worksheet is accurate. RN signs and dates verifying POC compliance and follow-up with any needs in comments section. Member is to initial under total hours worked every day.

West Virginia Medicaid Aged and Disabled Waiver Program

HOMEMAKER WORKSHEET Month_____Year_____

Member Name: _____ Plan Period: _____

Medicaid Number: _____ Level of Care:_____

DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Time Approved - Daily																
Time Arrived																
Time Left																
Total Hours																
Member's Initials																

DESCRIPTION OF SERVICE CARE - CIRCLE LEVEL OF ASSISTANCE (Circle only one.)

Bath: Sponge/Tub/Shower (Total/ Assist/ Supervise/Independent)																
Skin Care: Lotion/Shaving/Catheter Care																
Hair (Total/Assist/Supervise/Independent)																
Nails: Trim/File DO NOT TRIM NAILS OF DIABETIC																
Mouth Care: Dentures/Own Teeth/Oral Care (Total/Assist/Supervise/Independent)																
Dressing (Total/Assist/Supervise/ Independent)																
Ambulation: Walk/Cane/Walker/Wheelchair/ (Total/Assist/Supervise/Independent)																
Transfer (Total/Assist/Supervise/Independent)																
Toileting: Bathroom/Bedpan/ Bedside Commode/Incontinent/Empty Catheter Bag/Empty Ostomy Appliance (Total/Assist/ Supervise/ Independent)																
Positioning: Turn Every _____Hr(s) Up in Chair																
Bedmaking: Hospital Bed/Regular Bed																
Special Directions: Unsterile Dressings/Ice Pack/Elevate Feet/Other _____																
Assist with Medication (Assist/Prompt/Independent)																
Meals: Breakfast/Lunch/Dinner Diet:_____																
Essential Errands: 1X Week/PRN X1, 2, 3 (grocery, pharmacy, medical appts.)																
Laundry: Laundromat/In-Home/Apartment Complex																
Transportation																
Community Activities (not to exceed 20 hrs./mo.)																

ENVIRONMENTAL

DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Vacuum/Sweep																
Mop																
Dust																
Straighten																
Other: _____																

TREATMENTS PER PHYSICIAN'S ORDER

Temperature																
Pulse																
Respiration																
Blood Pressure																
Range of Motion																
Other: _____																

Date	Total Miles	Destination	Total Time

Must also be initialed in essential errands, transportation, and community activities blocks on page 1.

Certification that the Reported Information is Complete and Accurate

Member: _____

Date: _____

Homemaker: _____

Date: _____

RN: _____

Date: _____

COMMENTS:

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ATTACHMENT 12
REQUEST FOR LEVEL OF CARE CHANGE
PAGE 1 OF 2

INSTRUCTIONS

Must be filled out completely; leave no blank spaces; use N/A if necessary. Must have correct Medicaid number. Must be signed by the HM RN requesting Prior Authorization, and must be signed by member. Must be submitted to correct address or fax number as listed in upper portion of form. Request will not be considered unless all information is included.

BUREAU FOR MEDICAL SERVICES
REQUEST FOR LEVEL OF CARE CHANGE
Aged & Disabled Waiver Program

350 Capitol Street, Room 251
Charleston, West Virginia 25301-3707
Telephone: 304-558-1700
FAX: 304-558-1509

CONFIDENTIAL

MEMBER INFORMATION:

NAME: _____ BIRTHDATE: _____ /_____/_____ SS#:_____/____/_____

STREET ADDRESS: _____CITY:_____ STATE:_____ZIP:_____

COUNTY:_____ MEDICAID #: _____

CONTACT PERSON: _____PHONE NUMBER: _____
(If other than member)
RELATIONSHIP TO MEMBER_____

MEMBER'S SIGNATURE: _____

MEMBER REPRESENTATIVE'S SIGNATURE (if applicable):
_____

HOMEMAKER AGENCY INFORMATION:

AGENCY NAME: _____

AGENCY PROVIDER NUMBER: _____

OFFICE ADDRESS: _____CITY:_____ STATE:_____ ZIP:_____

PHONE: _____ FAX: _____

REQUIRED DATA TO BE SUBMITTED WITH THIS FORM:

1. A completed copy of this cover sheet with original signatures.
2. A narrative explaining the need for Level of Care change.
3. Current ADW PAS.
4. Current Homemaker Plan of Care.
5. Any additional documentation that substantiates the request.

SIGNATURE: _____ , RN DATE:_____

THE HOMEMAKER AGENCY WILL BE NOTIFIED OF THE DETERMINATION WITHIN 5 WORKING DAYS OF RECEIPT OF THE REQUEST.

CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 12A
PERSONAL OPTIONS REQUEST FOR
LEVEL OF CARE CHANGE
PAGE 1 OF 2

INSTRUCTIONS

Must be filled out completed; leave no blank spaces; use N/A if necessary. Must have correct Medicaid number. Must be submitted correct address or fax number as listed in upper portion of form. Request will not be considered unless all information is included.

BUREAU FOR MEDICAL SERVICES
REQUEST FOR LEVEL OF CARE CHANGE
Aged & Disabled Waiver Program – Personal Options

350 Capitol Street, Room 251
Charleston, West Virginia 25301-3707
Telephone: 304-558-1700
FAX: 304-558-1509

CONFIDENTIAL

MEMBER INFORMATION:

NAME: _____ BIRTHDATE: _____ /_____/_____ SS#:_____/____/_____

STREET ADDRESS: _____CITY:_____ STATE:_____ZIP:_____

COUNTY:_____ MEDICAID #: _____

CONTACT PERSON: _____PHONE NUMBER: _____
(If other than member)
RELATIONSHIP TO MEMBER_____

MEMBER'S SIGNATURE: _____

MEMBER REPRESENTATIVE'S SIGNATURE (if applicable):
_____

RESOURCE CONSULTANT INFORMATION:

NAME: _____

OFFICE ADDRESS: _____CITY:_____ STATE:_____ ZIP:_____

PHONE: _____ FAX: _____

REQUIRED DATA TO BE SUBMITTED WITH THIS FORM:

1. A completed copy of this cover sheet with original signatures.
2. A narrative explaining the need for Level of Care change.
3. A physician statement explaining the need for Level of Care change.
4. Current ADW PAS.
5. Current RMP
6. Any additional documentation that substantiates the request.

MEMBER SIGNATURE: _____

REPRESENTATIVE SIGNATURE (If applicable):_____

DATE:_____

THE MEMBER WILL BE NOTIFIED OF THE DETERMINATION WITHIN 5 WORKING DAYS OF RECEIPT OF THE REQUEST.

CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 13
CONFIDENTIALITY AGREEMENT
PAGE 1 OF 2

West Virginia Medicaid Aged and Disabled Waiver Program

CONFIDENTIALITY AGREEMENT

I, _____, understand that in the performance of my duties for _____, I will have access to privileged information about the member I am serving, and that such information may include medical, insurance, and other confidential/personal information. I agree to restrict my use of such information to the performance of my duties. I will not discuss the member's name, or otherwise reveal or disclose information pertaining to the member, except when in direct contact with representatives of the West Virginia Bureau for Medical Services, the West Virginia Bureau of Senior Services, the Quality Improvement Organization, the Fiscal/Employer Agent or _____, and then only for the purpose of assisting the member. I hereby acknowledge my obligation to respect the member's privacy and the confidentiality of the information pertaining to the member, and to exercise good faith and integrity in all dealings with the member and their personal information in the performance of my duties _____. I also understand that any unauthorized use or disclosure of information pertaining to the member may result in my immediate suspension and/or dismissal and may subject me to civil liability for breaching the member's right to privacy.

_____ _____

Employee Signature Date

_____ _____

Agency Representative Signature Date

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AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 13A
PERSONAL OPTIONS
CONFIDENTIALITY AGREEMENT
PAGE 1 OF 2

West Virginia Medicaid Aged and Disabled Waiver Program

PERSONAL OPTIONS CONFIDENTIALITY AGREEMENT

I, _____, understand that in the performance of my duties for _____, I will have access to privileged information about the member I am serving, and that such information may include medical, insurance, and other confidential/personal information. I agree to restrict my use of such information to the performance of my duties. I will not discuss the member's name, or otherwise reveal or disclose information pertaining to the member, except when in direct contact with representatives of the West Virginia Bureau for Medical Services, the West Virginia Bureau of Senior Services, the Quality Improvement Organization, the Fiscal/Employer Agent- Resource Consultant or _____, and then only for the purpose of assisting the member. I hereby acknowledge my obligation to respect the member's privacy and the confidentiality of the information pertaining to the member, and to exercise good faith and integrity in all dealings with the member and their personal information in the performance of my duties.

I also understand that any unauthorized use or disclosure of information pertaining to the member may result in my immediate suspension and/or dismissal and may subject me to civil liability for breaching the member's right to privacy.

_____ _____

Employee Signature Date

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CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 14
PRE-ADMISSION SCREENING PAS
PAGE 1 OF 7

This copy is for information only. The actual copy of an individual's PAS is in a computer generated format used by the QIO.

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

PRE-ADMISSION SCREENING

Reason for Screening: **Check Only One**

Facility/Agency/Person making referral:

A. Nursing Home Only ☐ Initial ☐ Transfer
B. Nursing Home waiting Waiver ☐ yes
C. A/D Waiver Only ☐ Initial ☐ Re-Evaluation
D. Personal Care ☐ Initial ☐ Re-Evaluation

NAME:_____
ADDRESS:_____
CONTACT PERSON:_____
PHONE:(___) _____ - _____
FAX: (___) _____ - _____

1. DEMOGRAPHIC INFORMATION

1. Individual's Full Name	2. Sex		3. Medicaid Number	4. Medicare Number
	F	M		
5. Address (Including Street/Box, City, State & Zip)				6. Private Insurance
7. County	8. Social Security Number	9. Birthdate (M/D/Y)	10. Age	11. Phone Number
12. Spouse's Name		13. Address (If different from above)		

14. Current living arrangements, including formal and informal support (i.e., family, friends, other services)

_____

_____

15. Name and Address of Provider, if applicable:

_____

_____

16. Medicaid Waiver Recipient a. ☐ Yes b. ☐ No c. ☐ Aged/Disabled d ☐ MR/DD

17. Has the option of Medicaid Waiver been explained to the applicant? a. ☐ Yes b. ☐ No

18. For the purpose of determining my need for appropriate services, I authorize the release of any medical information by the physician to the Department of Health and Human Resources of its representative.

✗_____ / _____/_____
SIGNATURE - Applicant or Person acting for Applicant Relationship Date

19. Check if Applicant has any of the following:

a. ☐ Guardian
b. ☐ Committee
c. ☐ Medical Power of Attorney
d. ☐ Power of Attorney
e. ☐ Durable Power of Attorney
f. ☐ Living Will
g. ☐ Other _____

Name & Address of the Representative_____

_____

_____

Phone: (_____) _____-_____

DATE: _____

II. MEDICAL ASSESSMENT

NAME:_____

20. Health Assessment - Include infectious diseases, nutritional needs, prior treatments, degenerative conditions, recent hospitalization(s), and/or surgery(ies) with dates - Date of most recent office visit. (Attach most recent Hospital Discharge Summary and Physical, if available)

_____
_____
_____
_____

21. Normal Vital Signs for the individual:

a. Height	b. Weight	c. Blood Pressure	d. Temperature	e. Pulse	f. Respiratory Rate

22. Check if Abnormal:

a. ☐ Eyes	g. ☐ Breasts	m. ☐ Extremities	s. ☐ Musculo-Skeletal
b. ☐ Ears	h. ☐ Lungs	n. ☐ Abdomen	t. ☐ Skin
c. ☐ Nose	i. ☐ Heart	o. ☐ Hernia(s)	u. ☐ Nervous System
d. ☐ Throat	j. ☐ Arteries	p. ☐ Genitalia-male	v. ☐ Allergies (Specify)_____
e. ☐ Mouth	k. ☐ Veins	q. ☐ Gynecological	
f. ☐ Neck	l. ☐ Lymph System	r. ☐ Ano-Rectal	

Describe abnormalities and treatment:

_____
_____
_____

23. Medical Conditions/Symptoms: [Please Grade as : (1) - Mild, (2) - Moderate, (3) - Severe]

a. ☐ Angina-rest	___	e. ☐ Paralysis	___	i. ☐ Diabetes	___
b. ☐ Angina-exertion	___	f. ☐ Dysphagia	___	j. ☐ Contracture(s)	___
c. ☐ Dyspnea	___	g. ☐ Aphasia	___	k. ☐ Mental Disorder(s)	___
d. ☐ Significant Arthritis	___	h. ☐ Pain	___	l. ☐ Other (Specify)	_____

24. Decubitus a. ☐ Yes b. ☐ No If yes, check the following:

A. Stage _____ B. Size _____ C. Treatment _____

Location: a. ☐ Left Leg c. ☐ Right Leg e. ☐ Left Hip g. ☐ Right Hip
b. ☐ Left Arm d. ☐ Right Arm f. ☐ Left Buttock h. ☐ Right Buttock

Other _____ Developed at: a. ☐ Home b. ☐ Hospital c. ☐ Facility

25. In the event of an emergency, the individual can vacate the building: (check only one)

a. ☐ Independently b. ☐ With Supervision c. ☐ Mentally Unable d. ☐ Physically Unable

DATE: _____
NAME:_____

26. Indicate individual's functional ability in the home for each item with the level number 1, 2, 3, 4, or 5. Nursing care plan must reflect functional abilities of the client in the home.

Item	Level 1	Level 2	Level 3	Level 4
a.__ Eating (not a meal Prep)	Self/Prompting	Physical Assistance	Total Feed	Tube Fed
b.__ Bathing	Self/Prompting	Physical Assistance	Total Care	
c.__ Dressing	Self/Prompting	Physical Assistance	Total Care	
d.__ Grooming	Self/Prompting	Physical Assistance	Total Care	
e.__ Cont./Bladder	Continent	Occas. Incontinent*	Incontinent	Catheter
f. __ Cont./Bowel	Continent	Occas. Incontinent* *less than 3 per wk.	Incontinent	Colostomy
g.__ Orientation	Oriented	Intermittent Disoriented	Totally Disoriented	Comatose (Level 5)
h.__ Transferring	Independent	Supervised/Assistive Devise	One Person Assistance	Two Person Assist.
i.__ Walking	Independent	Supervised/Assistive Devise	One Person Assistance	Two Person Assist.
j.__ Wheeling	No Wheelchair	Wheels Independently	Situational Assistance (Doors, etc.)	Total Assistance
k.__ Vision	Not Impaired	Impaired /Correctable	Impaired/Not Correctable	Blind
l.__ Hearing	Not Impaired	Impaired/Correctable	Impaired/Not Correctable	Deaf
m.__ Communication	Not Impaired	Impaired/Understandable	Understandable with Aids	Inappropriate/None

27. Professional and technical care needs (check all that apply).

a. ☐ Physical Therapy
b. ☐ Speech Therapy
c. ☐ Occupational Therapy
d. ☐ Inhalation Therapy
e. ☐ Continuous Oxygen
f. ☐ Ostomy
g. ☐ Suctioning
h. ☐ Tracheostomy
i. ☐ Ventilator
j. ☐ Dialysis
k. ☐ Parenteral Fluids
l . ☐ Sterile Dressings
m. ☐ Irrigations
n. ☐ Special Skin Care
o. ☐ Other _____

28. Individual is capable of administering his/her own medications (check only one).

a. ☐ Yes b. ☐ With Prompting/Supervision c. ☐ No Comment:_____

29. Current Medications	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

DATE:_____

III. MI/MR ASSESSMENT

NAME: _____

30. Current Diagnoses (Check all that apply)

a. □ None
b. □ Mental Retardation
c. □ Autism
d. □ Seizure Disorder (Age at onset: _____)
e. □ Cerebral Palsy
f. □ Other Developmental Disabilities (Specify: _____)
g. □ Schizophrenic Disorder
h. □ Paranoid Disorder
i. □ Major Affective Disorder
j. □ Schizoaffective Disorder
k. □ Affective Bipolar Disorder
l. □ Tardive Dyskinesia
m. □ Major Depression
n. □ Other related conditions (Specify:_____)

Date of last PASARR Level II Evaluation_____

31. Has an individual ever received services from an agency serving persons with mental retardation/developmental disability and/or mental illness? □ Yes □ No **If yes, specify agency**

Name_____ **Address**_____
Admission Date _____ **Discharge Date** _____

32. Has the individual received any of the following medications on a regular basis within the last two years?
□Yes □ No
33. Was this medication used to treat a neurological disorder? □Yes □ No

□ Chlorpromazine	□ Thorazine	□ Perphenazine	□ Trilafon	□ Haloperidol	□ Haldol
□ Promazine	□ Sparine	□ Fluphenazine	□ Prolixin	□ Molindone	□ Moban
□ Trifupromazine	□ Vesprin	□ Fluphenazine HCl	□ Permitil	□ Loxapine	□ Loxitane
□ Thioidazine	□ Mellaril	□ Trifluphenazine	□ Stelazine	□ Clozapine	□ Clozaril
□ Mesoridazine	□ Serentil	□ Chlorprothixene	□ Taractan	□ Procholorperazine	
□ Actiphenazine	□ Tindal	□ Thiothixene	□ Navane	□ Compazine	

Medication	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

34. Clinical and Psychosocial Data - Please check any of the following behaviors which the individual has exhibited in the past two years.

a. □ Substance Abuse (Identify_____)
b. □ Combative
c. □ Withdrawn/Depressed
d. □ Hallucinations
e. □ Delusional
f. □ Disoriented
g. □ Bizarre Behavior
h. □ Bangs Head
i. □ Sets Fires
j. □ Displays Inappropriate Social Behavior
k. □ Seriously Impaired Judgment
l. □ Suicidal Thoughts, Ideations/Gestures
m. □ Cannot Communicate Basic Needs
n. □ Talks About His/Her Worthlessness
o. □ Unable to Understand Simple Commands
p. □ Physically Dangerous to Self and Others, if Unsupervised
q. □ Verbally Abusive
r. □ Demonstrates Severe Challenging Behaviors
s. □ Specialized Training Needs
t. □ Sexually Aggressive

Does the individual have Alzheimer's, multi-infarct, senile dementia, or related condition? □ Yes □ No
Other (Specify) _____

DATE: _____

IV. PHYSICIAN RECOMMENDATION

NAME: _____

35. Prognosis - Check one only: a__ Stable b__ Improving c___ Deteriorating d__ Terminal

Other _____

36. Rehabilitative Potential (Check one only) a ___ Good b ___ Limited c___ Poor

37. Diagnosis:

a. Primary _____

b. Secondary_____

c. Other medical conditions requiring services_____

38. Physician Recommendations

A. FOR NURSING FACILITY PLACEMENT ONLY
On the basis of present medical findings, the individual may eventually be able to return home or be discharged.

a ___ Yes b___ No

If yes, check one of the following:

a. ☐ Less than 3 months
b. ☐ 3-6 months
c. ☐ Over 6 months
d. ☐ Terminal illness

B. I recommend that the services and care to meet these needs can be provided at the level of care indicated.

a. ☐ Nursing Home
b. ☐ Nursing Home waiting A/D Waiver
c. ☐ A/D Waiver
d. ☐ Personal Care

39. To the best of my knowledge, the patient's medical and related needs are essentially as indicated above (Must be signed by M.D. or D.O.)

_____

Physician's Signature MD/DO

_____

Date This Assessment Completed:

TYPE OR PRINT Physician's name/address below:

_____

_____

_____

_____

DISCLAIMER: Approval of this form does not guarantee eligibility for payment under the State Medicaid Plan.

NOTE: Information gathered from this form may be utilized for statistical/data collection.

V. ELIGIBILITY DETERMINATION

DATE: _____

NAME: _____

DEPARTMENT USE ONLY

LEVEL I (Medical Screen)

Medical and other professional personnel of the Medicaid Agency or its designees MUST evaluate each individual's need for admission by reviewing and assessing the evaluations required by regulation.

Exemptions from requirements for Level II Assessment

40. Does the individual have or require:

a. Diagnosis of dementia (Alzheimer's or related disorder)? ☐ **Yes** ☐ **No**

b. Thirty days of respite care? ☐ **Yes** ☐ **No**

c. Serious Medical Condition? ☐ **Yes** ☐ **No**

41. Medical Eligibility Determination:

a. ☐ **Nursing Facility Services/Aged/Disabled Waiver** **b.** ☐ **Personal Care Services**

c. ☐ **No Services Needed** **d.** ☐ **Optional Services**

42. PASARR Determination:

a ☐ **Level II required** **b** ☐ **Level II not required**

_____ _____

Nurse Reviewer's Signature - Title **Date** **Control Number**

Printed Name_____

WAIVER ONLY: Level of Care:_____ **Number of Hours:**_____

DEPARTMENTAL USE ONLY

LEVEL II (MI/MR Screen)

(Completed by PASARR Provider)

43. DETERMINATION:

a. Nursing facility services needed - Specialized services not needed.

b. Nursing facility services needed - Specialized services needed.

c. Alzheimer's or related disorder identified.

d. Thirty day Respite care needed.

e. Terminal illness identified.

f. Serious illness identified.

g. Nursing facility services not needed.

44. RECOMMENDED PLACEMENT:

a. Nursing Facility Services/Aged/Disabled Wavier

b. Psychiatric Hospital (21 years or under)

c. ICF/MR or MR/DD Waiver

d. Other-Identify:_____

_____ _____

PASARR Reviewer's Signature **Title** **Printed Name**

_____ _____

Agency Name **Date**

A COPY OF THIS FORM MUST BE IN THE INDIVIDUAL'S MEDICAL RECORDS

CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 15
MEDICAL NECESSITY
EVALUATION REQUEST
PAGE 1 OF 2

This form is to be submitted when an individual initially applies for the Medicaid Aged and Disabled Waiver Program or when a member re-evaluation is requested.

It must be signed by both the applicant and the physician, who must be an M.D. or D.O. The physician's signature must be original and is valid for 60 days. If the physician indicates that the applicant/member has Alzheimer's, Multi-Infarct, Senile Dementia, or Related Conditions, a contact person must be listed on this form.

MEDICAID AGED & DISABLED WAIVER PROGRAM
MEDICAL NECESSITY EVALUATION REQUEST (8/06)
Please return this form to West Virginia Medical Institute 3001 Chesterfield Place
Charleston, WV 25304 Fax: 304-346-8948 Toll-Free Fax: 800-293-3009
ENTIRE FORM MUST BE COMPLETED IN ORDER TO PROCESS

Please check one: _____Initial _____Reevaluation

APPLICANT/MEMBER INFORMATION:

Name: _____Date of Birth: ___/___/___ SSN: ____/___/____

Address: _____ City: _____ State: _____ Zip: _____

Medicaid #: _____ Phone #: _____ County: _____

CHECK ONE IF APPLICABLE:_____ Guardian _____ Power of Attorney _____ Committee

Contact Person: _____ Phone #: _____
(if applicant/member has Alzheimer's or other dementia, a contact person must be listed) (if other than applicant/member)

_____ _____
Signature of Applicant/Member or Representative Date

Case Management Agency (for Reevaluations Only): _____ Phone:_____

Address: _____ Fax: _____

REFERRING PHYSICIAN'S INFORMATION: (This information may be shared with the applicant/member. **THIS INFORMATION MUST BE LEGIBLE OR REQUEST WILL NOT BE PROCESSED.**)

Physician's Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient's Diagnosis(es): _____

_____

Other Pertinent Medical Conditions: _____

_____

CHECK IF PATIENT HAS: ☐ Alzheimer's ☐ Multi-Infarct ☐ Senile Dementia

☐ Related Conditions (please describe): _____
Is Patient Terminal? ☐ Yes ☐ No

_____ _____
Physician's Signature (M.D. or D.O. only; original required; valid for 60 days) Date

CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 16
REQUEST FOR HEARING

This form is to be completed by/for applicant or member if individual disagrees with an adverse action taken on his/her application or re-evaluation.

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES (MEDICAID)
REQUEST FOR HEARING

NAME: _____

ADDRESS: _____

APPLICANT/RECIPIENT ID#, if available: _____

TELEPHONE NUMBER WHERE YOU CAN BE REACHED: _____

I, _____, am requesting a fair hearing for the following reason(s):
(Print name)
_____
(Please list service that was denied or terminated. Be as specific as possible. Use other side of form if necessary for more space.)

You may be contacted by a representative of the Department of Health and Human Resources regarding this request. You may be requested to participate in a pre-hearing conference (most likely by telephone). You may choose to participate in your hearing by phone or in person.

Which type of hearing would you prefer (please check one):

_____ Applicant participate by telephone conference
_____ Applicant in person at local office
_____ Applicant to attend hearing at Bureau for Medical Services office in Charleston (with reimbursement for travel mileage, if requested)

This type of hearing can be changed with notice to hearing examiner seven days prior to hearing.

Signature: _____
Date: _____

_____ I need special accommodation for _____
_____ I need help with transportation reimbursement for the hearing.

If hearing is by telephone and you have any documents to present, please mail your documents before the hearing to the hearing examiner whose name is on the hearing notice that you will receive. Please be advised that Department attorneys and nurse witnesses may appear by telephone.

If you will be represented by an attorney or other individual, to the extent you know, list his/her name, address, and telephone number:
_____
_____

Return this request to: Bureau for Medical Services
Appeals Section
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3706

A Staff member will try to contact you by telephone within approximately five days of receipt of this form. After the telephone contact, you will then be notified in writing of the date and time of the hearing. If we are unsuccessful in contacting you by telephone, you will receive written notice of the hearing date and time within 30 days.

Aged & Disabled Waiver Program 8/06

CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 17
INCIDENT REPORT
PAGE 1 OF 4

This form is to be completed by the provider agency when a simple or critical incident occurs or if there is evidence/suspicion of abuse, neglect, or exploitation. All incidents must be documented and traced by the provider in order to identify trends and the need to improve/amend provider policies and procedures if necessary.

Section I, Member Information: to be completed by the person reporting the incident.

Section II, Description of Incident: to be completed and signed by the person reporting the incident. This should a factual account of the incident. The incident must be reported to supervisory staff.

Section III, Incident Information: to be completed and signed by the agency RN, LSW, or LC who immediately reviews each Incident Report Form and determines if the incident is Simple, Critical, or Alleged Abuse, Neglect or Exploitation. The RN, LSW, or LC will check all areas under "Alleged Incident(s)" that apply.

Section IV, Incident Follow-Up: to be completed by Investigator who is assigned by the Agency Director/Administrator; must be signed by Investigator and Director/Administrator. A detailed description of the incident investigation must be documented with findings and conclusions; note all persons interviewed. Indicate which agencies/individuals were informed of the incident. Describe follow-up actions taken and any systemic action within the agency taken. Indicate any staff training that might be helpful in preventing further incidents, any recommendations for additional support of the ADW member, and any recommended modifications to the member's Service Coordination Plan or Plan of Care.

Section V, Death: to be completed and signed by agency personnel when a member has died. If certain information is unknown, make a notation in the appropriate space.

West Virginia Medicaid Aged & Disabled Waiver Program
INCIDENT REPORT
Confidential

Incident Date: _____
Time: _____ a.m./pm.

***SECTION I* – Member Information (completed by person reporting incident)**

LAST:	FIRST:

ADDRESS: CITY: STATE: ZIP:

COUNTY: DOB: GENDER: ☐ M ☐ F

***SECTION II*– Description of Incident (completed & signed by person reporting incident)**

Describe in detail the reportable incident including other persons involved. Attach additional page(s) if necessary.

When was the Immediate Supervisor Notified? Date: _____ Time: _____
Supervisor's Name:_____
Signature of Person Reporting Incident: _____Date: _____

***SECTION III* - Incident Information (completed by Agency RN, LSW or LC)**

INCIDENT TYPE: ☐ SIMPLE ☐ CRITICAL ☐ ALLEGED ABUSE, NEGLECT, EXPLOITATION

ALLEGED INCIDENT(S) Check all that apply:

ABUSE: ☐ PHYSICAL ☐ SEXUAL ☐ VERBAL ☐ EMOTIONAL

NEGLECT: ☐ NUTRITIONAL ☐ MEDICAL ☐ SELF ☐ ENVIRONMENT

EXPLOITATION: ☐ FINANCIAL ☐ THEFT ☐ DESTRUCTION OF PROPERTY

ACCIDENT/INJURY: ☐ (REQUIRING TREATMENT BEYOND FIRST AID)

DEATH (Complete page 3) ☐ ANTICIPATED ☐ UNANTICIPATED ☐ DATE OF DEATH**:** _____

TREATMENT ERROR: ☐ MEDICATION ☐ OTHER (Describe): _____

OTHER: ☐ MISSING PERSON ☐ ABANDONMENT ☐ RIGHTS VIOLATION ☐ OTHER (Describe):

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West Virginia Medicaid Aged & Disabled Waiver Program
INCIDENT REPORT
Confidential
Page 2

***SECTION IV* – Incident Follow-up (completed by Investigator; signed by Investigator & Agency Director/Administrator)**

Member's Name (as reported in Section I): _____

Provide a detailed description of incident investigation. Attach additional page(s) if necessary.

_____ _____ _____
SIGNATURE of INVESTIGATOR **TITLE** **DATE**

INDICATE WHICH of the FOLLOWING AGENCIES and/or INDIVIDUALS HAVE BEEN INFORMED

LEGAL GUARDIAN?	☐ YES	☐ NO	NAME: _____	DATE: _____
HOMEMAKER?	☐ YES	☐ NO	NAME: _____	DATE: _____
CASE MANAGER?	☐ YES	☐ NO	NAME: _____	DATE: _____
DOCTOR?	☐ YES	☐ NO	NAME: _____	DATE: _____
APS/CPS?	☐ YES	☐ NO	NAME: _____	DATE: _____
CORONER?	☐ YES	☐ NO	NAME: _____	DATE: _____
POLICE?	☐ YES	☐ NO	NAME: _____	DATE: _____

OTHER PROVIDER
☐ YES ☐ NO

If Yes, Note Below:

Describe follow-up actions taken and any systemic actions within the agency being taken to assure health and safety. Attach additional page(s) if necessary.

_____ _____
SIGNATURE OF AGENCY DIRECTOR/ADMINISTRATOR **DATE**

_____ _____ _____
SIGNATURE of INVESTIGATOR **TITLE** **DATE**

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***SECTION V* – Death (completed & signed by agency personnel)**

If incident is regarding the death of the member, please include the following information:

Member Information as Reported in Section I.

Member's Name: _____

Incident Date: _____ **Incident Time:** _____

1. Date of Death: **Time of Death:**

2. Place of Death:

☐ ADULT DAY CARE
☐ HOME
☐ HOSPITAL
☐ OTHER SETTING (PLEASE EXPLAIN/DESCRIBE):

3. Describe all life-saving measures, if any were applicable, that were attempted at the time of death (i.e. , CPR administered, 911 called, transported to hospital, etc.), if known*:*

4. Circumstances immediately preceding the death, if known:

5. If no life-saving measures were taken, please explain why not (i.e., was there a no-code status, do not resuscitate (DNR) order, etc.), if known*:*

_____ _____ _____
SIGNATURE **TITLE** **DATE**

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CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 17A
PERSONAL OPTIONS
INCIDENT REPORT
PAGE 1 OF 4

This form is to be completed by the individual witnessing the incident when a simple or critical incident occurs or if there is evidence/suspicion of abuse, neglect, or exploitation. All incidents must be documented and submitted to the F/EA-RC.

Section I, Member Information: to be completed by the person reporting the incident.

Section II, Description of Incident: to be completed and signed by the person reporting the incident. This should a factual account of the incident.

Section III, Incident Information: to be completed by the person reporting the incident.

Section IV, Incident Follow-Up: a detailed description of the incident investigation must be documented with findings and conclusions.

Section V, Death: to be completed and signed by staff member or F/EA-RC when a member has died. If certain information is unknown, make a notation in the appropriate space.

West Virginia Medicaid Aged & Disabled Waiver Program
PERSONAL OPTIONS INCIDENT REPORT
Confidential

Incident Date: _____
Time: _____ a.m./pm.

***SECTION I* – Member Information (completed by person reporting incident)**

LAST: FIRST:

ADDRESS: CITY: STATE: ZIP:

COUNTY: DOB: GENDER: ☐ M ☐ F

***SECTION II*– Description of Incident (completed & signed by person reporting incident)**

Describe in detail the reportable incident including other persons involved. Attach additional page(s) if necessary.

When was the Resource Consultant Notified? Date: _____ Time: _____
Resource Consultant's Name:_____
Signature of Person Reporting Incident: _____Date: _____

***SECTION III* - Incident Information**

INCIDENT TYPE: □ SIMPLE □ CRITICAL □ ALLEGED ABUSE, NEGLECT, EXPLOITATION

ALLEGED INCIDENT(S) Check all that apply:

ABUSE:	☐ PHYSICAL	☐ SEXUAL	☐ VERBAL	☐ EMOTIONAL
NEGLECT:	☐ NUTRITIONAL	☐ MEDICAL	☐ SELF	☐ ENVIRONMENT
EXPLOITATION:	☐ FINANCIAL	☐ THEFT	☐ DESTRUCTION OF PROPERTY	
ACCIDENT/INJURY:	☐ (REQUIRING TREATMENT BEYOND FIRST AID)			
DEATH (Complete page 3)	☐ ANTICIPATED	☐ UNANTICIPATED	☐ DATE OF DEATH**:** _____	
TREATMENT ERROR:	☐ MEDICATION	☐ OTHER (Describe): _____		
OTHER:	☐ MISSING PERSON	☐ ABANDONMENT	☐ RIGHTS VIOLATION	☐ OTHER (Describe):

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PERSONAL OPTIONS INCIDENT REPORT
Confidential
Page 2

***SECTION IV* – Incident Follow-up (completed by Investigator; signed by Investigator)**

Member's Name (as reported in Section I): _____

Provide a detailed description of incident investigation. Attach additional page(s) if necessary.

_____ _____ _____
SIGNATURE of INVESTIGATOR **TITLE** **DATE**

INDICATE WHICH of the FOLLOWING AGENCIES and/or INDIVIDUALS HAVE BEEN INFORMED

LEGAL GUARDIAN? ☐ YES ☐ NO NAME: _____ DATE: _____
HOMEMAKER? ☐ YES ☐ NO NAME: _____ DATE: _____
CASE MANAGER? ☐ YES ☐ NO NAME: _____ DATE: _____
DOCTOR? ☐ YES ☐ NO NAME: _____ DATE: _____
APS/CPS? ☐ YES ☐ NO NAME: _____ DATE: _____
CORONER? ☐ YES ☐ NO NAME: _____ DATE: _____
POLICE? ☐ YES ☐ NO NAME: _____ DATE: _____

OTHER PROVIDER
☐ YES ☐ NO

If Yes, Note Below:

Describe follow-up actions taken and any systemic actions within the agency being taken to assure health and safety. Attach additional page(s) if necessary.

_____ _____ _____
SIGNATURE of INVESTIGATOR **TITLE** **DATE**

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West Virginia Medicaid Aged & Disabled Waiver Program
Confidential
PERSONAL OPTIONS INCIDENT REPORT

***SECTION V* – Death (completed & signed by staff member or resource consultant)**

If incident is regarding the death of the member, please include the following information:

Member Information as Reported in Section I.

Member's Name: _____

Incident Date: _____ **Incident Time:** _____

1. Date of Death: **Time of Death:**

2. Place of Death:

☐ ADULT DAY CARE
☐ HOME
☐ HOSPITAL
☐ OTHER SETTING (PLEASE EXPLAIN/DESCRIBE):

3. Describe all life-saving measures, if any were applicable, that were attempted at the time of death (i.e. , CPR administered, 911 called, transported to hospital, etc.), if known*:*

4. Circumstances immediately preceding the death, if known:

5. If no life-saving measures were taken, please explain why not (i.e., was there a no-code status, do not resuscitate (DNR) order, etc.), if known*:*

_____	_____	_____
SIGNATURE	**TITLE**	**DATE**

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CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 18
AGENCY MONTHLY INCIDENT TRACKING REPORT
PAGE 1 OF 2

This report is to be completed monthly and mailed to the West Virginia Bureau of Senior Services. All incidents shall be tracked by the provider in order to identify trends and the need to improve/amend provider policies and procedures if necessary.

In “Type of Incident” column, list either “Alleged Abuse, Neglect, Exploitation,” “Critical Incident,” or “Simple Incident.”

In “County” column, list county in which incident occurred.

Indicate “yes” or “no” in “Follow-Up” and “APS Referral” columns.

Enter total of all reported incidents and total of all member hospitalizations for the reporting month.

Agency Representative must sign and date.

Agency Name and Site: _____

Provider Name: _____ Reporting Month/Year: _____

HMA _____ CMA_____

*Type of Incident	County	Follow-up Yes/No	APS Referral Made Yes/No

Total Reported Incidents: _____ **Total Reported Hospitalizations: _____**
(hospitalizations should only be reported by HMA's)

_____ _____
Agency Representative Signature/Title **Date**

***Type of Incident: Allegation of Abuse and/or Neglect**
Critical Incidentimple Incident

CHAPTER 501
AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 19
DUAL SERVICE PROVISION REQUEST
PAGE 1 OF 2

Please see §501.7.12 for complete information about request to provide the same member with both ADW and Personal Care services.

WEST VIRGINIA MEDICAID
AGED & DISABLED WAIVER AND PERSONAL CARE
DUAL SERVICE PROVISION REQUEST

MEMBER INFORMATION Submission Date: _____

Name: _____ Medicaid #: _____

Current ADW LOC: _____

REQUEST INFORMATION

Period for this Request (NO LONGER THAN 6 MONTHS): _____ to _____

Requested PC units per month: _____ Total Number of PC units for the Requested Period: _____

SERVICE INFORMATION

Current ADW HMA: _____ Current CMA: _____

PC Agency: _____Provider #: _____

PC Address: _____

PC Phone #: _____ FAX #: _____

DATE OF HM RN, CM, PC RN, AND MEMBER MEETING: _____

_____ _____
SIGNATURE OF ADW HM RN **SIGNATURE OF CM**

_____ _____
SIGNATURE OF REQUESTING PC RN **SIGNATURE OF MEMBER OR REPRESENTATIVE**

REQUIRED DATA TO BE SUBMITTED WITH THIS FORM:

1. A completed copy of this cover sheet with original signatures.
2. A narrative describing how services will be utilized and verification that the ADW & PC services will not be duplicated.
3. Documentation of caregivers for both programs and their relationship to member.
4. Current ADW PAS 2005, or PAS 2000 if prior to 11/2005.
5. Current PC Medical Eligibility Assessment or PAS 2000 if prior to 11/2005.
6. Current ADW and PC RN Assessments.
7. Current ADW POC.
8. Proposed PC POC.
9. Any additional documentation that substantiates the request.

SENIOR CENTER PROVIDERS SEND REQUESTS TO: WV Bureau of Senior Services
State Capitol, 1900 Kanawha Blvd. E.
Charleston, WV 25305
FAX: (304) 558-6647

ALL OTHER PROVIDERS SEND REQUESTS TO:
WV Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301
FAX: (304) 558-1509

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AGED & DISABLED WAIVER SERVICES
NOVEMBER 1, 2003

ATTACHMENT 19A
PERSONAL OPTIONS
DUAL SERVICE PROVISION REQUEST
PAGE 1 OF 2

Please see §501.7.12 for complete information about request to provide the same member with both ADW and Personal Care services.

WEST VIRGINIA MEDICAID
AGED & DISABLED WAIVER AND PERSONAL CARE
PERSONAL OPTIONS DUAL SERVICE PROVISION REQUEST

MEMBER INFORMATION Submission Date: _____

Name: _____ Medicaid #: _____

Current ADW LOC: _____

REQUEST INFORMATION

Period for this Request (NO LONGER THAN 6 MONTHS): _____ to _____

Requested PC units per month: _____ Total Number of PC units for the Requested Period:

_____

SERVICE INFORMATION

Current HM: _____ Current CM (if applicable):

_____

PC Agency: _____Provider #: _____

PC Address: _____

PC Phone #: _____ FAX #: _____

DATE OF HM RN (if applicable), CM (if applicable), PC RN, AND MEMBER MEETING: _____

_____ _____
SIGNATURE OF ADW HM RN (IF APPLICABLE) **SIGNATURE OF CM (IF APPLICABLE)**

_____ _____
SIGNATURE OF REQUESTING PC RN **SIGNATURE OF MEMBER OR REPRESENTATIVE**

REQUIRED DATA TO BE SUBMITTED WITH THIS FORM:

10. A completed copy of this cover sheet with original signatures.
11. A narrative describing how services will be utilized and verification that the ADW & PC services will not be duplicated.
12. Documentation of caregivers for both programs and their relationship to member.
13. Current ADW PAS.
14. Current PC Medical Eligibility Assessment.
15. Current PC RN Assessments.
16. Current ADW RN Assessment (if applicable).
17. Current ADW RMP.
18. Proposed PC POC.
19. Any additional documentation that substantiates the request.

SENIOR CENTER PROVIDERS SEND REQUESTS TO: WV Bureau of Senior Services
State Capitol, 1900 Kanawha Blvd. E.
Charleston, WV 25305
FAX: (304) 558-6647

ALL OTHER PROVIDERS SEND REQUESTS TO:
WV Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301
FAX: (304) 558-1509

11/06