Roads to Community Living

Washington State's Money Follows the Person Project

The Purpose of this chapter is to educate staff about Roads to Community Living (RCL), what benefits the program has offered to participants and to provide instruction on how to utilize the services through the close of the project.

Ask an Expert

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WHAT IS THE ROADS TO COMMUNITY LIVING PROGRAM?

Roads to Community Living (RCL) is a statewide demonstration project funded by a federal "Money Follows the Person (MFP)" grant. The grant was received by Washington State from the federal Centers for Medicare and Medicaid Services (CMS). The purpose of the RCL demonstration project was to investigate what services and supports will successfully help people with complex, long-term care needs transition from an institution to a community setting.

Services and supports from the RCL demonstration project have proven successful and are being used to shape changes to Washington State's long-term care system. This will result in more people with complex long-term care needs being able to remain independent or transition from institutional into community settings in Washington State.

The RCL demonstration project has received approval to extend new RCL enrollments through the end of **2028**; the last date for individuals to receive RCL services has also been extended through **12/31/2029.** All new HCLA RCL participants will be enrolled and managed by ALTSA HQ. RCL enrollment procedures for DDA remain unchanged. ALL RCL participants must be disenrolled by **12/31/2029.** The grant will be closed out with all expenditures finalized, reconciled, and submitted to CMS by **09/30/2031**.

As part of sustainability planning, demonstration and supplemental services that have proven to be useful will be added to the state plan and/or waiver. Those supplemental or demonstration services with low or no utilization will be allowed to sunset with the program. This process has already started and will continue. The goal is to ensure a seamless transition in Home and Community Based Services (HCBS) available in existing state plan and waiver programs once RCL is no longer available.

WHO IS ELIGIBLE FOR THE RCL PROJECT?

The RCL demonstration project will transition the last individual onto RCL services on 12/31/2027. The last date for individuals to receive RCL services is 12/31/2028 therefore all RCL participants must be disenrolled by that date. For those RCL participants who may be re-institutionalized during their 365 day post transition demonstration period, they will be allowed to finish the remainder of their 365 day demonstration period on or before the 12/31/2028 project end date. The grant will be closed out with all expenditures finalized, reconciled and submitted to CMS by 09/30/2031.

Individuals eligible for RCL are:

- People of any age with a continuous, qualified stay of **60 days or longer** in one or more qualified institutional setting (hospital, nursing home, RHC/ICF-ID) without a break in institutional care; OR
- Individuals in an inpatient psychiatric hospital with a continuous stay of **60 days or longer** who are 20 years or younger, or 65 and older. (**Note:** The RCL enroll disenroll Help screen in CARE provides a list of RCL qualified inpatient psychiatric settings.)

AND each of the following:

- Receiving Medicaid-paid inpatient services immediately prior to discharge, including most of the ACES N group, also known as MAGI (see exceptions below)
- Interested in moving to a qualified community setting which includes the following: DDADDA Group Home, In-Home, Assisted Living Facility (ALF), Adult Residential Care (ARC), and Enhanced Adult Residential Care (EARC);
- On the day of institutional transition to begin the 365-day demonstration year, RCL participants must be functionally and financially eligible for waiver or state plan services (or Fast Tracked).

  Please note: Medicaid recipients receiving services through HCS may be fast-tracked into the program while institutionalized to allow them to access pre-transition services while pending LTSS financial eligibility. However, it's important to note that while participants can receive pre-transition services through the fast-track process, they must meet financial eligibility for waiver or state plan services on the day of institutional transition.

RCL services for individuals while institutionalized who plan to transition to an unqualified setting:

Individuals may enroll in RCL while institutionalized to access services for pre-transition support, even if they plan to transition to a setting that is not considered a qualified RCL setting after discharge. This ensures the use of federally funded RCL services rather than relying on state funded service packages (CTSS/WA Roads) if the individual meets RCL eligibility. RCL services may be used for individuals who are planning to transition from institutional care into:

- A designated Residential Support Waiver (RSW) setting
- An Enhanced Adult Residential Care - Specialized Dementia Care Program (SDCP)
- The Program of All-Inclusive Care for the Elderly (PACE).
- An Adult Family Home (see MB 026-008 for details)

Upon transition, the individual will need to be disenrolled from RCL, since ongoing RCL services cannot be provided in an unqualified setting. Please refer to the section **What is the process to disenroll an individual from RCL prior to discharge?** for detailed steps.

Individuals who are not eligible for RCL are:

- Individuals in the AO1, AO5, L04, L24, N20, N21 and N25 state funded non-citizens medical benefits.
- Individuals receiving a TSOA benefit (TO2). These individuals will need to apply for a Medicaid LTSS Program to facilitate an RCL Enrollment. Individuals must choose the program which is most appropriate to meet their needs.

Residents in inpatient psychiatric facilities of more than 16 beds which are primarily engaged in providing diagnosis and treatment of care to persons with behavioral health diagnoses aged 21-64 years may be excluded from enrollment onto the Roads to Community Living program. To confirm whether your client is eligible for RCL, please review the list in the RCL enroll disenroll Help screen in CARE or reach out to: DSHSALTSARCLReferrals@dshs.wa.gov.

How to request RCL Enrollment for a qualified individual

Individuals may enroll onto RCL for multiple demonstration periods when eligibility requirements are met. Create an email including the following client information:

- Client name
- Client ACES ID
- Estimated discharge date, if known
- Expected community setting at discharge (this can be multiple settings for those who are entertaining dual track planning)
- Indicate whether pre-transition services are anticipated
- Qualified institutional name and admission date
    - Individual may be enrolled early for RCL, when the institutional stay is expected to exceed 60 days. Indicate this information in the email if requesting early enrollment.
- Any requests for transition planning support (if needed)

- Send the email
    - For HCS clients send the email to: DSHSALTSARCLReferrals@dshs.wa.gov
    - For DDADDA client send the email to: DDARCLENROLLMENTINTAKE@DSHS.WA.GOV

After the RCL enrollment request is received and processed, an email reply will be sent with the RCL Participant form attached. The case manager provides a copy of this form to the client. HCS Headquarters staff will submit the form to DMS for HCS, and RMT for DDADDA .*(Example of RCL participation form is located under the Resources section)*

HCS and DDADDA Headquarters staff will complete RCL enrollment procedures, including adding the RCL RAC.

Once enrolled, RCL services can be utilized while institutionalized to assist the participant's transition to the community. RCL participants can continue utilizing RCL services for 365 days in the community with the first day beginning on day of discharge. The days used in the community are automatically tracked in the RCL enroll disenroll screen in CARE. See Authorizing RCL services for HCS clients for more information.

WHAT SERVICES ARE OFFERED UNDER RCL?

Participants enrolled in this project have access to:

- All services currently available under the Medicaid State Plans: Medicaid Personal Care (MPC) and Community First Choice (CFC) and
- Home and Community Services (HCS) and Developmental Disability Administration (DDADDA) Medicaid waivers provided in in-home settings (such as COPES); and
- Additional services available through RCL that are above and beyond what is offered in any other state plan or waiver as outlined below.

RCL project services are only available to the participant while in the institutional setting and during the project demonstration year (365 days after leaving the facility and residing in a community setting).

All RCL project services must be authorized by HCS, Area Agency on Aging (AAA), or DDADDA case managers.

For DDADDA: If the person is exiting an RHC, contact the RCL liaison in the DDADDA region where the person would like to live to determine what services are available.

WHAT ADDITIONAL SERVICES ARE AVAILABLE THROUGH RCL FOR HCLA CLIENTS?

In addition to qualified services that are also available through state plan and waiver services [e.g. personal care [Individual Provider (IP), CDWA, agency caregiver, and Assisted Living facility (ALF)], Nurse Delegation, Adult Day Health, etc.], the following services are available for RCL participants when indicated in the plan of care and authorized by the case manager. For those RCL participants who are on the Address Confidentiality Program, please refer to Chapter 3: Assessment and Care Planning for further information.

Client Training: Behavior Support Services: H2019 (HCS Only)

Behavior Support services are for participants transitioning from institutional to community settings or requiring stabilization while residing in the community in instances where the authorized Medicaid benefit amount, duration or scope of service does not meet the individual's needs. This service may be helpful in situations where a client is struggling to keep caregivers due to the way they interact with others, or when they're not making progress toward their healthcare or transition goals. A change in health status or living situation may lead to emotional or behavioral shifts, like increased stress, frustration or withdrawal that begin to interfere with daily life. In other cases, tensions within the household or family system may be creating a stressful environment for the client. These are some examples where Behavior Support Services may help address underlying issues and improve stability.

Identifying a Behavior Support Provider:
Behavior Support Providers are contracted and monitored by the local Area Agency on Aging (AAA). To locate a Behavior Support Provider in the client's area, refer to the vendor/provider list maintained by that AAA. Once you identify a provider, reach out to them directly to confirm whether they currently have capacity to serve the individual.

The Behavior Support Services Contract (1044XP) is used for Client Training-Behavior Support and the qualifications include:

- Master's Degree in Psychology, Education, Social Work, or related discipline, or a Doctoral Degree in Psychology, Education, or related field.

Client Training-Behavior Support Service Code:

- H2019 Behavior Support – Individual Note: there is a limit of 80 units (20 hours)/month in a three-month (92 day) period for client support training services. This service can be authorized again after the initial three-month (92 day) period has ended with a local ETR.

CARE Assessment Documentation for Client Training-Behavior Support:

- On the Treatments screen in CARE: Select Client Training/Waiver under the Rehab Restorative Training header.
- On the Pre-Transition and Sustainability screen found below the Client Details section in CARE, select the Sustainability Goals tab. From the drop down, select the goal description, and describe the goal of behavior support in the comments. This section helps the provider understand the specific reasons for the development of a behavior support plan.
- On the Care Plan Supports screen, assign Client Training to the behavior support provider.
- Send the chosen behavior support provider a copy of the Assessment Details, Service Plan, and Sustainability Goals.

Provider responsibilities once the service is authorized:
The behavior support provider will begin with an assessment of the client's behavior to determine the causes, triggers, and purposed behind the challenging behavior. The behavior support provider will **develop a behavior support plan** within 30 days of the client's assessment and provide this to the case manager. The behavior support plan will address things such as:

- Factors that are associated with an individual's documented or identified behaviors.

- Written strategy of behaviorally specific interventions designed to address those behaviors and promote optimal functioning with recommendations for improving the client's overall quality of life, teaching methods and environmental changes designed to decrease the behaviors that may be impacting the client remaining or transitioning to a community setting.
- Direct interventions with the client to decrease the behavior that compromises their ability to remain in the community. This could include demonstrating and practicing new interventions and skills with formal and informal supports and significant others to support the individual in their community setting.
- Case Consultation regarding escalating situations.
- Make recommendations for treatment and assisting with making referrals for community behavioral health services
- The assigned case manager sends the behavior support plan to DMS.

This service is also available through COPES. See Chapter 7d: COPES for more information.

Community Choice Guiding (CCG): SA263 (HCS Only)

Payment for specialty services which provides assistance and support to ensure the participant's successful transition to the community and/or maintenance of community living as authorized by HCS and/or AAA staff. CCG services may include, but are not limited to the following:

- Locating and arranging appropriate, accessible housing; including working with local housing authorities and other community resource providers. Assisting with subsidy applications, move-in logistics, and coordinating with other providers to promote housing stability.
- Supporting clients in setting housing goals, identifying preferences, and addressing barriers.
- Set up client's new home such as arranging lease documentation, arranging utility hook-ups or acquiring furnishings and household goods.
- Assist a client with touring Adult Family Homes (AFH) and Assist Living Facilities (ALF) to determine whether this setting is preferred by the client.
- Supporting the establishment of a network of relevant client partners: nursing or institutional facility staff, case managers, community providers (including AFH and ALF providers), medical personnel, legal representatives, paid caregivers, family members, housing agencies and landlords, informal supports and any other involved parties.
- Assisting with filling out forms and obtaining needed documentation to aid in the client's successful transition from an institutional setting or stabilization within the community (forms may be related to Public Benefits, housing subsidy, lease agreements, etc.).
- Providing emergent assistance to avoid utility shut-off and/or eviction.
- Assisting client in developing a basic household budget.

  NOTE: If the client needs additional assistance to manage their finances or learn independent living skills related to household management, consider authorizing **Client Training: Non-Medical** services.
- Assisting client with locating and arranging transportation resources to effectively connect with community and community resources. An example would be a one-time purchase and reimbursement of a bus pass.

NOTE: Transportation for medical appointments should be provided by existing non-emergency medical transportation benefits if the client is eligible.

- Coordinating and linking the client to resources which will establish or stabilize their community setting, including arrangements with pharmacies, primary care physicians, financial institutions, utility companies, housing providers, social networks, local transportation, housing budgeting, Durable Medical Equipment providers and other needs identified in the Plan of Care.
- Shopping for necessary household goods/items or paying for rental deposits (to include first month rent), utility hookup fees, or rent/emergency rental assistance service. This service assists clients transitioning out of institutions or when needed to stabilize a client's community setting.

  NOTE: The provider is also reimbursed for the authorized purchases after it is verified the client received the goods or service. Authorization for the item/service is under a separate service code and case managers will process the reimbursement(s) for these one-time goods or services supports to the CCG as timely as possible. This reimbursement should not exceed 30 days after the CCG has provided an invoice/receipt as proof of the purchase.

- Assisting to find a qualified caregiver. See additional information in COPES
- When determining whether to authorize a CCG to assist with identifying a client's preferred residential setting, please refer to Transition Academy SharePoint for additional guidance on the Room and Care residential search tool procedure.

Note: CCGs do not have access to Carina but can assist clients with other tasks related to locating a potential IP and guiding the potential IP to CDWA for hiring, when authorized by the case manager. The case manager should follow the steps detailed in MB H21-083. See additional information in Chapter 7d: COPES.

Tasks outside of CCG scope of work:

- Activities that require specific training or licensure/certification (e.g. pest eradication, moving services)
- Anything that has to do with a client's personal finances (e.g. cashing personal check, loaning money to client, using client's money as down payment, etc.)
- Becoming a co-signer (e.g. rental applications, loans, etc.)
- Driving a client or representative's owned vehicle (even with insurance required to provide transportation).
- Enter a client's home without the client's/representative's expressed/written permission.
- Perform tasks or skill building which fall under the Client Training scope of work. See additional Client Training information in Chapter 7d: COPES.

Steps to Authorize Community Choice Guide (CCG) Services:

1. Contact a contracted CCG provider to discuss the case. The provider will determine capacity to assist the client with the goals and tasks. CCG providers can decline referrals without providing a reason.

2. Add the CCG business name to the Contact Details screen under Client Details.
3. Add "Community Integration" and "Community Transition Services" and/or "Community Transition Goods and Items" in the Treatment section of the Medical Screen in CAREWeb.
    a. Enter a brief comment for each treatment. Examples include:
        i. Community Integration: CCG to assist with transitioning a client to the community OR CCG to assist with stabilizing client in the community.
        ii. Community Transition Services/Community Transition Goods and Items: CCG to assist with purchasing goods or services as authorized.
4. Add the CCG Provider to the Providers screen within the CARE Planning section of assessment.
5. Assign Community Integration to the CCG on the Support Screen.
6. Complete the Sustainability Goals outlining the goals and tasks the CCG is assigned to assist the client with.
7. Send documents to CCG Provider:
    a. Sustainability Goals
    b. Signed DSHS Consent form
    c. Assessment Details (if available)
    d. Service Summary (if available) – CCG Providers are not required to sign the Service Summary
8. Ensure appropriate RAC is entered. CCG Services (SA263) are available through RCL, CFC (SA266 only) RSW, COPES, CTSS, or WA Roads. Please check individual LTC Manual chapter for additional information.
9. Authorize SA263 and/or SA266 (only if purchasing an AT Good).
10. Create an approval Planned Action Notice (PAN) for all services the client is authorized to receive as outlined in CARE (except for any services provided through WA Roads)
11. CCG Providers may either fax the Activity Tracking Form directly to DMS or email it to the assigned case manager. The assigned case manager is responsible for reviewing this document and ensuring the Activity Tracking Form is uploaded to DMS. If the Activity Tracking Form is sent directly to the case manager, they must submit the form to DMS. If the CCG sends the form directly to DMS, the assigned case manager will receive a notification on their Barcode To-Do list indicating that the Activity Tracking Form is ready for review.

For additional resources please see the CCG Services SharePoint site.

NOTE: Services such as pest eradication, janitorial services and packing/moving services must be performed by a contracted provider who holds the Community transition and Sustainability Services (CTSS) contract and paid directly via ProviderOne. Authorizing a CCG to perform the CTSS scope of work is prohibited. HCS may consider using the HQ managed purchasing card when there is CTSS contracted provider capacity concerns. Further instructions on HCS use of the HQ purchasing card can be found in Chapter 10: Nursing Facility Case Management and Relocation

Community Choice Guide Issuing Payment for AT Good SA266

AT Goods can be purchased from an AT contracted provider with the AT Goods subcode, or if needed, a third-party purchaser such as a Community Choice Guide (CCG) for HCS/AAA clients.

Based on a client's eligibility:

- The case manager will supply the detailed information for the covered assistive technology good, which retailer it is to be purchased from, the amount it should cost, and where it should be delivered.

The provider is also reimbursed for the authorized purchase of assistive technology after it is verified the client received the good. Authorization for the good is under a separate service code and case managers will process the reimbursement(s) for assistive technology to the CCG as timely as possible. This reimbursement should not exceed 30 days after the CCG has provided an invoice/receipt as proof of the purchase.

Note: See Resources section for the Community Choice Guide Activity Tracking form. For more information on how to authorize CCG services please refer to the CCG Services SharePoint
For more information and guidance related to CCG services and authorization steps, please review Chapter 7d - COPES.

Community Transition Services- Items: SA296

Items may include, but are not limited to:

- Goods necessary to establish a residence such as essential household items and furnishings.
- Goods needed to help stabilize community living for a client.
- This service code can be utilized at any time during the enrollment and transition period for community transition goods as identified in the CARE plan.
  - For AFH Settings reference WAC 388-76-10685, and for Assisted Living Settings reference WAC 388-78A-3011 which outline resident unit furnishings in these settings. In the event a residential setting indicates they are unable to provide the required furnishings as outlined in WAC, notify the provider of their requirements as outlined in WAC, and also submit a referral to Residential Care Services (RCS) Complaint Resolution Unit (CRU) to document the provider's inability to meet residential unit furnishings per WAC. Referrals can be made online Residential Care Services Online Incident Reporting | DSHS (wa.gov) or via phone at 1-800-562-6078.

See *Which Program to Use: Transition and Sustainability Goods and Services* in the Appendix as a reference guide.

NOTE: Community Transition Services – Items (SA296) does not permit payment of tips. With online orders/pickups, some companies have added an automatic tip to the overall total of the transaction. This cannot be reimbursed using Community Transition Services-Items. If the automatic tip cannot be removed from the transaction total, shopping at these companies should be avoided altogether.

Paying a money order/casher's check fee as part of a move-in cost (payment of first month's rent/deposit) is allowable.

Community Transition Services: SA297

Services include:

- Packing assistance
- Moving assistance
- Utility set up fees or deposits
- Non-recurring health and safety assurances such as pest eradication, allergen control and/or one time cleaning.
- Rental deposits (all pre-tenancy funds required can be bundled as one deposit, staying within the service code limit)
- Non-recurring rental insurance

See *Which Program to Use: Transition and Sustainability Goods and Services* in the Appendix as a reference guide.

NOTE: Services such as pest eradication, janitorial services and packing/moving services must be performed by a contracted provider who holds the Community transition and Sustainability Services (CTSS) contract and paid directly via ProviderOne. Authorizing a CCG to perform the CTSS scope of work is prohibited. HCS may consider using the HQ managed purchasing card when there is CTSS contracted provider capacity concerns. Further instructions on HCS use of the HQ purchasing card can be found in Chapter 10: Nursing Facility Case Management and Relocation

RCL Supplemental Goods & Services: SA295

For services and supports after the client transitions out of an approved institutional setting which supports community living, use the SA295 service code. This service code can be used for the purchase of necessary one-time goods or services where the authorized Medicaid scope of service does not meet the client's needs. This service code should also be used to reimburse a CCG for Trial Visits. Excluded are rental subsidies.

NOTE: A contract is not required if another payment mechanism is utilized.
Options include:

- Using a client services HCS P-Card (state issued credit card available to HCS HQ staff); or
- Authorizing a contracted provider to pay for rental deposits and community living set-up fees directly and be reimbursed (such as a CCG).

Unit compensation to the contracted provider for issuing or coordinating payment does not count towards the funding limits of SA295, SA296, and SA297.

Short-Term Rental Assistance

This supplemental service will cover up to 6 months of short-term rental assistance and associated utility expenses to bridge the gap between transition to the community and when federal, state, or local housing assistance is secured.

To access this resource, case managers will need to utilize the established process for the HCLA Bridge Subsidy as outlined in Chapter 6a: ALTSA Subsidies & GOSH Services.

Motel Interim Stay for Transitions: SA294 U1

The Motel Interim Stay for Transitions (MIST) is a service to pay for a short-term motel/hotel stay offered to minimize the number of voucher/subsidy holding clients who discharge to and/or experience episodes of homelessness while in housing search. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service is authorized for a 6-month period at a time. MIST currently cannot be offered to clients who do not have a housing subsidy/voucher in hand to utilize. Please Reference Chapter 6b: Interim Housing Resources (Motel Interim Stay for Transitions & Emergency Rental Assistance) for additional Housing Resource policy information.

Environmental Modifications- In Home: S5165 UA

Minor physical adaptations to an RCL participant's in home setting as authorized in the plan of care to increase health, welfare and safety and provide greater independence. Must be of direct medical or remedial benefit to the participant, including but not limited to:

- Installation of ramps and grab bars
- Widening of doorways
- Modification of bathroom facilities
- Installation of specialized electric or plumbing systems.
- Installation of Assistive Devices

Excluded are adaptations or improvements that are of general utility and are not of direct benefit to the individual (e.g., carpeting, roof repair, central air conditioning, etc.). See General Utility modifications for more information. Adaptations which add to the total square footage are also excluded.

Note: The Housing Modification Property Release Agreement (Form 27-147) is required for Environmental Modifications completed in residences which are not owned by the client. For more information see Chapter 7d: COPES.

Environmental Modifications- Residential: S5165 UB

Minor physical adaptations to an RCL residential setting as authorized in a participant's plan of care to increase health, welfare and safety and provide greater independence. Must be of direct medical or remedial benefit to the participant, including but not limited to:

- Installation of ramps and grab bars
- Widening of doorways
- Modification of bathroom facilities
- Installation of specialized electric or plumbing systems.
- Excluded are adaptations or improvements that are of general utility and are not of direct benefit to the individual (e.g., carpeting, roof repair, central air conditioning, etc.). See General Utility modifications for more information. Adaptations which add to the total square footage are also excluded.

Environmental Modifications- General Utility Allowance: S5165 U3

Minor general utility adaptations to an RCL resident's home as authorized in a participant's plan of care to increase health, welfare and safety and provide greater independence. Must be of direct medical or remedial benefit to the participant, including but not limited to:

- replacing hot water heaters
- minor roof repairs
- repair of drywall
- Repairs to specialized electric or plumbing systems.

Note: The In home Environmental Adaptations General Utility and Repair Property Release Agreement (Form 27-147A) is required for clients who own their home or reside in a family owned home.

Pantry Stocking: SA420-U1

One-time, nonrecurring, setup expenses for necessary food items essential for basic living. These are pantry items necessary to help eligible clients transition from an institutional setting to an independent living setting. This is separate funding source than Community Transition Services (CTS): Goods and therefore is excluded from the CTS funding limits.

Allowable expenses are those necessary to enable a person to establish a basic household and stock their pantry with food goods that are essential for living in the community before food benefit is received or reinstated.

Federal approval requires that this service is limited to food items and pantry items only.

Assistive Technology (Non-CFC): SA075 U2

AT Goods and AT Services must be:

1. In response to an assessed and documented need in the Client's assessment and agreed to by the Client;
2. Authorized by the case manager to be implemented as part of and in accordance with a Client's service plan;
3. Within the coverage and any specific parameters of the Client's eligible program; and
4. Not covered by Medicare, Apple Health, other insurances or resources.

AT Goods, including assistive equipment, are adaptive/assistive devices/items that increase a client's independence or substitutes for human assistance with an ADL, IADL, or health-related task.

The list of RCL AT covered goods is in alignment with the CFC AT Covered Items List and is updated in the CFC Chapter of the Long Term Care Manual (Chapter 7b). Further details, to include how to find and AT contracted provider, and limitations regarding this service, are located in the CFC Chapter.

Technology Support Consultation and Technical Assistance: H2014 U9

Technology Support Consultation and Technical Assistance services are for participants transitioning from an institutional stay to a community setting. Individuals statewide who want to transition to a community setting will have access to receiving Technology Consultation and Technical Assistance along with their Assistive Technology (AT) benefit.

Technology Support Consultation will identify AT that could provide solutions to potential barriers to discharge. The Assistive Technology Provider (ATP) will evaluate the client's environment and abilities and make referrals for appropriate assisted technology to the case manager. The use of Assisted Technology will support clients with ADL's and or IADL's to help client's community setting be more sustainable.

The participant will receive training and Technical Assistance from the ATP to support transition from the institutional setting to their community setting to ensure that they can use their AT to meet their needs.

To capture this in CARE, choose Other in the Treatments screen, indicate Assistive Technology Supports in the comments and assign to the Technology Support Services Provider in the Supports table.

For details on entering the CARE authorization and making the referral for this service, see Desk Aid for Technology Support Consultation and Technical Assistance

The Technology Provider will **develop a technology support plan during the consultation with client** and provide this to the case manager. The Assistive Technology Provider address things such as:

- Assessment of technology support environment and skill building strategies
- Technology support planning
- Recommendations for maximizing existing technology and incorporating additional technology resources to increase access, engagement, and utilization of assistive technology.
- Case consultation with case managers as well as client and formal or informal caregivers

- Coordinating the purchasing of Assistive Technology
- Installation of Assistive Technology devices and equipment
- Education and training on incorporating technology use directly with the client
- Education and training to DSHS staff regarding assistive device utilization, digital literacy, and functional limitation concerns
- Assistance considers site-specific circumstances and culture

For additional resources please see the AT SharePoint HCS SharePoint site.

Smart Care Device: SA077_U2

The Smart Care Device is a proactive AI device that interacts and engages with a client to provide support through proactive suggestions, cuing and reminders for ADL &/or IADL tasks or health-related activities, and accessing their community.

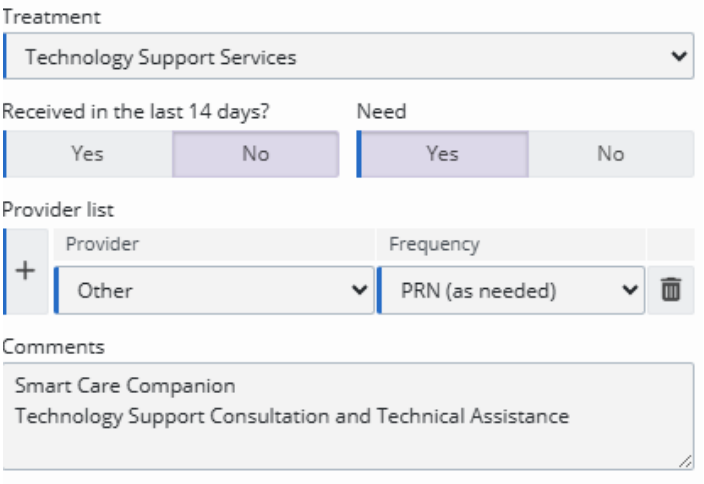
The Smart Care Device is available to clients receiving in-home care services on the Roads to Community Living (RCL) program. This service is also available through CFC – please reference Chapter 7b for information on authorizing this service through CFC.

For the Smart Care Device, an in-home client may be eligible if they:

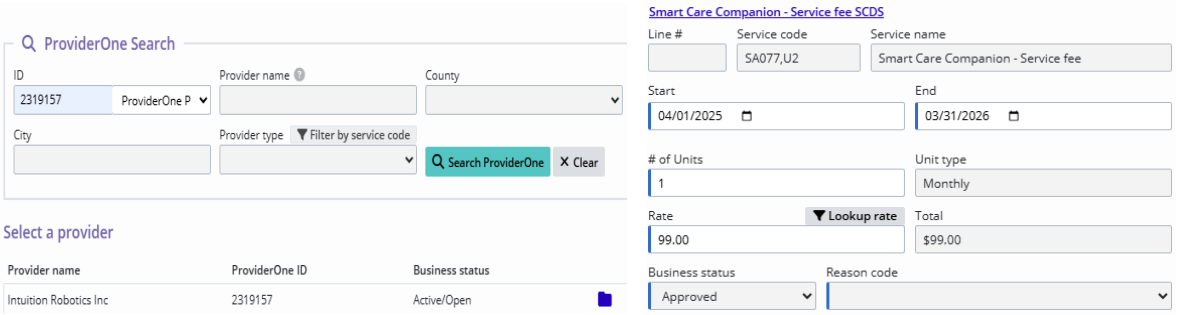
- Are 18 years old or older,
  - Are able to effectively use the Smart Care Device – able to hear and see the device, and speak and understand English (no other languages are currently available),
- Have Wi-Fi internet service

  - To make referral for ElliQ Smart Care Device, go to the ElliQ DSHS Landing Page to complete provider designation form. Once submitted a confirmation email will be sent to case manager email prompting Provider One Authorization.

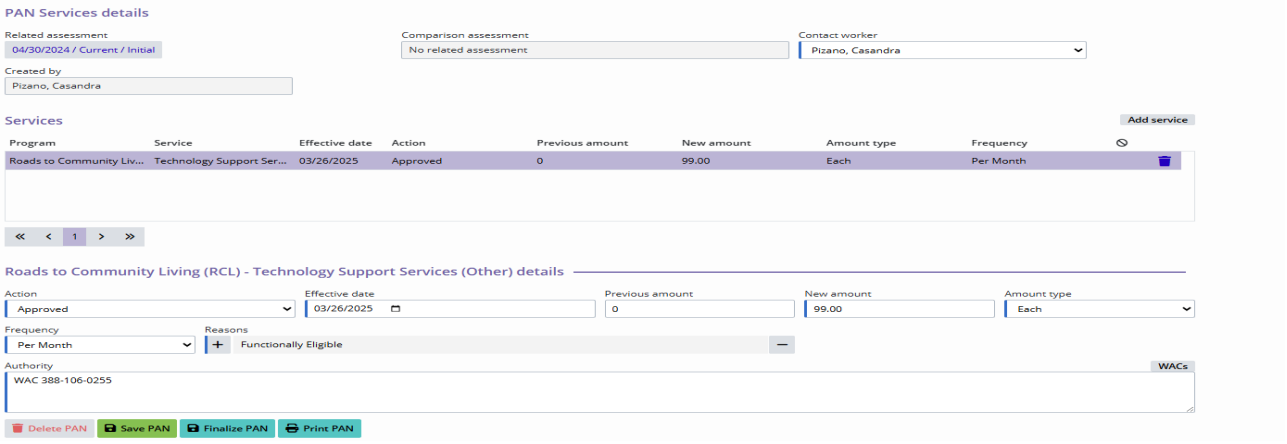
- Under Treatments, choose “Technology Support Services” under programs. In the Provider field, choose “Other”. Include a short comment noting Smart Care Device, and Technology Support Consultations and Technical Assistance, if applicable.



- Update Provider one authorization in CARE to include rate and frequency of service.



- Complete PAN indicating Roads to Community Living (RCL) as program. In the service field choose Other HCS Services indicating Technology Support Services as the name of service.



- **Note:** Planned Action Notices (PAN) must be completed and provided to the participant and their representative when HCLA makes a decision regarding

eligibility, service, or denial/termination of a provider. The PAN includes information regarding the planned action and appeal rights.

For additional resources please see the AT SharePoint ,HCS SharePoint site.

Other services available under Roads to Community Living:

- Durable Medical Equipment (See Blanket code lists). When an RCL enrolled participant will benefit from an item of DME which must be provided as part of a transition plan prior to leaving the institutional setting, please reach out the RCL Enrollment specialist in your area for guidance. RCL programmatic flexibilities may allow for the procurement of the DME outside of the usual and traditional pathways as outlined in the 1915 (c) waiver requirements or through Apple Health benefits, however should not be used to supplant a Medicaid Benefit available through these state plan processes. Spec. Medical Equipment Service/repair: K0739
- Non-Medical Equipment and Supplies: SA421
- Client Training Medical: H2014-UC
- Client Training Non-Medical: H2014-UD
- Non-Medical Transportation: T2003
- Technical Assistance: S5115-U6
- Wellness Education: SA080
- Home Delivered Meals: S5170
- Private Duty Nursing In Home: T1000
- Specialized Goods/Services Purchasing Card: SA638
- Nurse Delegation: H2014 U5
- Skilled Nursing: T1002, T1003,
- Personal Care

Personal Care Service Codes	P1 Code
Personal Care In Home	T1019 U6
Personal Care Residential ARC	T1020 U2
Personal Care ARC Enhanced	T1020 U3
Assisted Living	T2031

- Personal Emergency Response System (PERS):

PERS Service Codes	P1 Code
PERS Installation Fee	S5160
PERS standard/basic unit	S5161
- Fall Detection add-on service (AT) to PERS standard/basic unit	S5161 – U1
- GPS add-on service (AT) to PERS standard/basic unit	S5161 – U2
- Medication Mgmt System add-on (AT) to PERS standard/basic unit	S5161 – U3

When in doubt, send questions and concerns to:

HCS: DSHSALTSARCLReferrals@dshs.wa.gov

DDADDA: ddarclenrollmentintake@dshs.wa.gov
HQ RCL Staff are happy to help!

Are all the RCL services available anywhere in the State of Washington?

Some services may be limited according to regional contracted provider availability. One of the goals of the RCL demonstration project is to help identify and expand contracted provider capacity and resource availability when the services and supports meet the RCL demonstration project criteria.

*If there is a specific client need for a contracted service provider that does not exist in their local area, notify the associated Area Agency on Aging contracts management and the HCS Resource Support and Development teams of this need.

Where may individuals receive services under RCL?

Places where individuals may receive services during the RCL 365 day post transition demonstration period are called qualified community settings. Qualified community settings under RCL include:

- The individual's owned or leased home or apartment (including Supported Living when the client holds the lease)
- A home or apartment owned or leased by the participant's family; or
- Assisted Living Facility (ALF), Adult Residential Care (ARC), and Enhanced Adult Residential Care (EARC).

AUTHORIZING RCL SERVICES FOR HCS CLIENTS

Once the HCS individual is enrolled in RCL on the RCL Enroll/Disenroll screen, the case worker may authorize pre-transition services while the participant is residing in the qualified institutional setting:

1. Have the individual or their representative complete the Consent for Services (DSHS 14-012) form, Acknowledgement of Services (DSHS 14-225) form, and Rights and Responsibilities (DSHS 16-172) Form assisting as necessary.
2. Document in the CARE assessment, a SER and/or the Sustainability Goals screen in CARE the service(s) being authorized, and/or the items to be purchased,
3. Following all procedures in the Social Services Authorization Manual, authorize necessary services. List all RCL services on the appropriate screen(s) in CARE. For example, if an individual is authorized RCL Client Training: Behavior Support services, "Client Training/Waiver" should be included in the Treatment screen, choosing the appropriate provider type and frequency on the Provider List. In the "Supports" screen connect this treatment to contracted Professional Support provider as a paid task.

For RCL services that do not have a distinct treatment, follow this guide as to which treatments to choose:

RCL Service	Treatment Screen
Community Choice Guiding	Community Integration
Community Transition Goods or Items (including One Time Pantry Stocking)	Community Transitions Goods or Items
Community Transition Services	Community Transition Services
Client Training: Behavior Support	Client Training/Waiver
Non-Medical Transportation	Non-medical transportation
Technology Support Consultation & Technical Assistance Smart Care Device	Technology Support Services
Short Term Rental Assistance (to include MIST)	Housing Subsidy

When the participant is approaching a transition date from a qualified institution:

1. Complete the CARE assessment including all transition services authorized and move it to current.
    - **Reminder:** an assessment can be moved to Current status with any authorized paid service. Many RCL participants receive a variety of services to support transition planning and these are authorized prior to personal care starting.
2. Ensure all services and identified equipment are delivered and in place at the time of transition.
3. Send care planning documentation to the participant and any individuals involved in care planning, as necessary, per instructions in Chapter 3: Assessment and Care Planning.
4. Follow instructions as outlined in the LTC Manual to obtain approval on the plan of care, send all required documents/forms to the individual/representatives and providers, and complete required documentation of these activities.

Tip: As a best practice, it is helpful for the individual to visit their new setting prior to transition to determine if additional supports or services will be needed. Additional equipment may be identified, or it could be as simple as rearranging items for easier access to prevent falls.

For example, if a person is returning to their own home after a hip replacement, they may need items in the kitchen moved to a new place so they can reach them without falling when they are home alone (for example, pots and pans that are kept in a low cabinet may need to be relocated). This could include a home evaluation by OT/PT or a home visit with a CCG or other contracted provider.

Upon confirmation of participant's transition from the institution:

Update the following fields on the RCL Enroll/Disenroll screen in CARE:

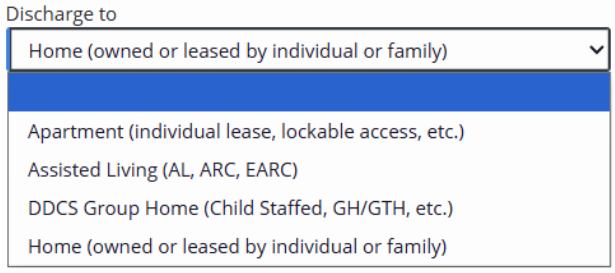
1. Enter the discharge date in the "Actual discharge date" field (this must match the discharge date on the NFCM/Acute Care hospital/State hospital screen).
   - Please note: The individual's 365-day demonstration year clock does not begin until this field is complete.

     Note: If an individual transitions to an RCL unqualified setting (AFH, RSW, PACE, SDCP, etc.) they will need to be disenrolled, and a different program will need to be started the day of discharge. The *Actual Discharge Date* field will be left blank. To disenroll, follow instructions within the section: What is the process to disenroll an individual from RCL prior to discharge?

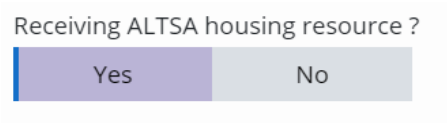
2. The "Projected end date" field will populate with an auto calculated RCL year-end date,



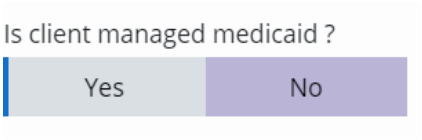
3. Discharged To (setting type).



4. Indicate whether or not the participant is receiving HCLA Housing resources as part of their transition plan
   - *Review LTC Manual* Chapter 6a-d: Housing Resources for HCLA Clients *for more information regarding HCLA Housing resources*



5. Indicate whether or not the participant is receiving managed Medicaid services (N series or enrolled with a Managed Care plan for apple health benefits).
   - *Review LTC Manual* Chapter 22: Managed Care *for more information regarding managed Medicaid services*



6. Create a new entry on the Contact Details screen with updated address information.

7. On the Care Plan screen, ensure "Roads to Community Living" is the selected program in the "Client chosen program" field.

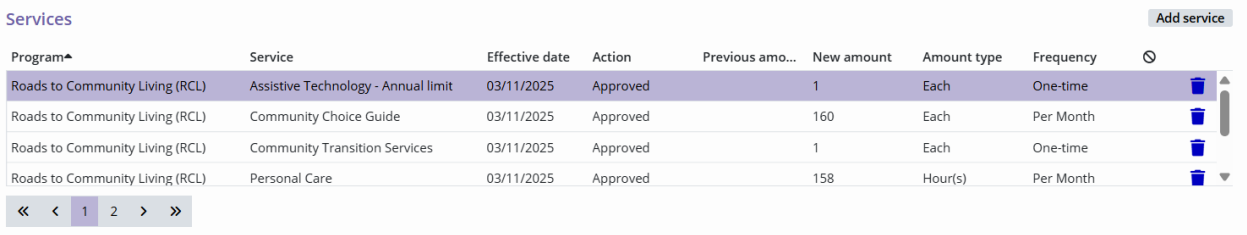
8. Update the RCL RAC end date. Ensure the RCL RAC end date matches the "Projected end date" field date from the RCL Enroll/Disenroll screen



9. Using the DSHS 14-443 form, notify the Public Benefits Specialist of the discharge date from the nursing facility/acute care hospital/psychiatric hospital and complete the RCL portions. The RCL start date is the date of discharge and the RCL end date is the projected end date as indicated on the RCL Enroll/disenroll screen. (Reminder the RCL 365 day end date needs to match the RCL RAC end date).
    - **Note:** For Managed Medicaid participants the RCL Demonstration period is documented in the client tab in Barcode under Customer Information Notes. See Chapter 10: Nursing Facility Case Management and Relocation for more information about the NFLOC screen in ProviderOne.

Important note: The case worker should closely monitor all financial letters during the 365 day RCL demonstration period. If the participant receives a termination letter, contact the financial worker immediately. *Eligibility should not be terminated due to changes in functional or financial status.* ***Participants who were eligible for RCL at discharge are eligible for RCL until the end of their 365 day demonstration service year regardless of change in functional or financial status.***

10. Create the authorization(s) and send a Planned Action Notice
    - **Note: Planned** Action Notices (PAN) must be completed and provided to the participant and/or their representative when HCLA takes an action that impacts the client's benefits. The PAN includes information regarding the planned action and hearing rights.



11. As a best practice, it is highly recommended to schedule a joint case staffing between the case worker and AAA/Residential Care Case Manager to facilitate a smooth transition.

12. Transfer the case to the AAA or Residential Care Case Manager per local policy. Refer to existing Case Transfer Guidelines in Chapter 5 of the LTC Manual. Make sure to note on the Case Transfer form that the individual is an RCL participant and include the projected end date of their 365 day demonstration year as detailed on the RCL Enroll/Disenroll screen and as indicated on the RCL RAC screen.

When in doubt, send questions and concerns to:
HCS: DSHSALTSARCLReferrals@dshs.wa.gov
DDADDA: DDARCLENROLLMENTINTAKE@DSHS.WA.GOV
HQ RCL Staff are happy to help!

AUTHORIZING RCL SERVICES FOR DDADDA INDIVIDUALS

While the person is still in the institutional facility, the CRM shall:

Send enrollment referral to DDARCLENROLLMENTINTAKE@DSHS.WA.GOV

When the participant is approaching discharge from the facility, the DDADDA CRM shall:

- Complete the DDADDA assessment.
- Following all CARE notification protocols, distribute necessary assessment related documents (PAN, Service Summary, etc.).
- Notify the financial worker that the individual is an RCL participant on the RCL version of the DSHS 15-345 in Barcode and include the following:
  a) The date of discharge from the institutional setting onto RCL services.
  b) The setting that RCL services will take place (in-home, group home etc.).
  c) The new address.
  d) A request to complete the Authorized Representative (AREP) screen in ACES per normal procedures so the CRM can receive the financial letters.
  e) A request that the financial worker open the RCL Program in ACES.

Upon confirmation of the participant's transition from the institution:

Update the following fields on the RCL Enroll/ Disenroll screen in CARE:

- Actual Discharge Date (this must also be updated on the NFCM screen if discharging from a nursing facility).
  - Please note: The individual is not considered to be on their 365 day demonstration period until this field is complete.

- Discharged To (setting type).
- Receiving ALTSA Housing Resources- Indicate "yes/no" when asked if the participant is receiving an HCS housing resource. For DDADDA recipients, they will always choose "no."
- Indicate if the participant is managed Medicaid (check in ACES or ProviderOne screen in CARE if you are unsure).
- Update the Contact Details screen with the current address information.
- Update the end date for the RCL RAC. The RCL end date is the Projected End Date listed on the RCL Enroll Disenroll screen which populates once the discharge date is entered.

> **Important note:** The HCS/DDADDA case worker should closely monitor all financial letters during the 365 day RCL demonstration period. If the participant receives a termination letter, contact the financial worker immediately. *Eligibility should not be terminated due to changes in functional or financial status.* ***Participants who were eligible for RCL at discharge are eligible for RCL until the end of their 365 day demonstration service year regardless of change in functional or financial status.***

How much may I spend on RCL services?

RCL services can only be authorized for a **MAXIMUM of 365** days following discharge from an institutional setting. Services may be used during the demonstration year and are intended to be intensive, if needed, at the beginning of transition, and to lessen over time. Case managers must also plan for services which are necessary for maintenance of community living after the end of the 365 day period. You can find the RCL end date by checking the "Projected End Date" field on the RCL Enroll/Disenroll screen in CARE. This field auto-populates based once the *Actual Discharge Date* is entered.

Since one of the goals of the project is to promote flexibility and develop individualized and person-centered transition plans, spending guidelines **are dependent on the participant's circumstances and needs**. (The DDADDA Assessment and rates calculator will be used to determine the funding available for individuals enrolled in RCL through DDADDA.)

When utilizing RCL Services:

- Document in the CARE Assessment, a SER or the Sustainability Goals screen:
  - How the services or supports being authorized are of direct benefit to the participant's successful transition and community living.
  - Ensure authorized services are consistent with needs identified in the CARE assessment.
  - The process followed that demonstrates that any equipment purchased is in addition to that supplied by Medicare/Medicaid and does not replace it.

Follow all purchasing protocols as outlined in Chapter 3: Assessment and Care Planning:

- Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Social Services Invoice/Receipt Packet Cover (02-615).

- The case manager must verify the participant received the goods purchased. This can be done by having the contracted provider, like a Community Choice Guide (CCG) verify or by contacting the client directly. The case manager must document the receipt of goods in a SER.
- Services can be reauthorized at the end of the Maximum Length of Service included on the Service Code Data Sheet.
    - For example, if additional services are needed after authorizing Client Training: Behavior Support services for a three month period of time, three additional months may be authorized.
- Service maximums are cumulative for each service *per occurrence*. For example, if the service limit for a given code is $5000, all the goods purchased over the maximum length of service per the Service Code Data Sheet cannot total more than $5000 without an ETR during a transition. If the service is needed at a later date due to a different event, the service may be authorized again with the service limit available. See Service Code Data sheets for detailed information.

ETR Considerations Personal Care:

HQ ETRs will only be used for additional necessary personal care hours or daily residential rate.

Community Transition or Sustainability Services:

If authorizations for a necessary service/item exceed the maximum amount allowable, you must complete a local ETR prior to exceeding the maximum limit. Each region will use their local ETR process for RCL services.

Bathroom Equipment:

Follow all procedures to request bathroom equipment through the ETR process as outlined in the Social Services Authorization Manual. Please reference bathroom equipment ETR protocol in Ch 7d: COPES.

Chapter 3: Assessment and Care Planning has detailed information on the Exception to Rule (ETR) Process.

WHAT ARE THE CASE WORKER'S RESPONSIBILITIES WITH THE RCL PROGRAM?

Once a participant is enrolled in the RCL program, the case worker provides primary case management, including the authorization of RCL services.

How often do I need to assess the participant?

As outlined in Chapter 3: Assessment and Care Planning, the CM/CRM/CNC will use professional discretion to determine if an updated assessment is needed during the course of the client's 365 day

RCL service year. The Annual assessment will likely be completed within the RCL service year and likely will not correspond with the RCL end date. RCL will remain in place until the end date as indicated on the RCL Enroll/Disenroll screen in CARE. A general check in with the client within 60 days prior to the end of the RCL 365 day service year is recommended to plan for the transition onto waiver or state plan services when the RCL services end. *See **Actions for HCS, AAA and DDADDA to prepare for the end of the RCL 365 day service period** section for more information.*

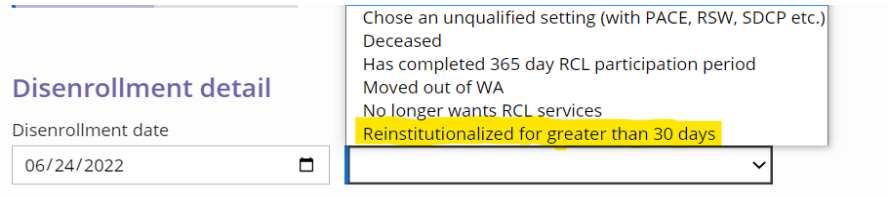
If a participant is re-admitted into an institutional setting:

For nursing facility admissions, follow all protocols in the Ch 10 Nursing Facility Case Management and Relocation chapter (making sure to update the NFCM screen in CARE with the admit date and facility name).

If an RCL participant re-admits to an institutional setting (nursing facility, acute care hospital, State Psychiatric Hospital, residential habilitation center, etc.) after transitioning to the community, please note the following:

- For an institutional stay less than 30 days, do not disenroll the participant (the RCL 365 day service period continues uninterrupted) and **do not end date the RCL RAC**.
    - Keep services which will support the RCL enrollee's return to the community in place. This could include Community Choice Guide services and Client Training Services.

- For an institutional stay greater than 30 days, the participant must be disenrolled on the RCL enroll disenroll screen in CARE. Email the HQ RCL Policy Unit (HCS: DSHSALTSARCLReferrals@dshs.wa.gov or DDADDA: ddarclenrollmentintake@dshs.wa.gov), if needed, to assist with these steps:
    a) **Record the Disenrollment Date and Reason**
        i. The Disenrollment Date is the date of re-admission to the institution once the stay has extended beyond 30 days (backdating to accurately reflect the readmission date is acceptable).



        ii. Choose "Reinstitutionalized for greater than 30 days" in the Disenrollment Reason field of the RCL Enroll/ Disenroll screen in CARE.
        iii. Choose from the drop down the reason the participant was reinstitutionalized.

        Note: by entering the disenrollment due to "Reinstitutionalization for greater than 30 days", the participant's "RCL clock" is paused to ensure the participant utilizes their allotted 365 days in the community. Once re-enrolled and discharged, any days used prior to reinstitutionalization are counted and thus the clock continues. The RCL

Enroll/Disenroll screen accounts for prior days used and automatically updates the correct Projected end date on the RCL Enroll/Disenroll screen in CARE upon the next transition.

b) **Re-Enroll the Client:** A client can be immediately re-enrolled to access RCL services to support their transition and return to the community. Re-Enrollment pauses the RCL "clock", recalculating the Projected End Date by accounting for prior days used in the community on RCL. This will ensure the client can access the remainder of their RCL demonstration period. This process can be followed as needed throughout the participant's RCL demonstration period until there is no time remaining on the RCL "clock".

Note: For re-enrollment after disenrollment due to reinstitutionalization, a new 60-day length of stay is not required. A new Consent Form (DSHS 14-012) does not need to be signed by the individual.

Email the HQ RCL Policy Unit (HCS: DSHSALTSARCLReferrals@dshs.wa.gov or DDADDA: ddarclenrollmentintake@dshs.wa.gov), if needed, to assist with these re-enrollment steps:

i. Prior to authorization any transition services, create a new enrollment on the RCL Enroll/Disenroll screen in CARE by clicking on the "plus (+)" button.
ii. Enter the *Enrollment Date*. The Enrollment date can be as early as one day following the Disenrollment date if transition planning begins immediately, or it can be as late as the same day as the subsequent Actual Discharge Date if no transition services were utilized.
iii. Select the *Institution Type* where the client is currently admitted. The *Admit Date* will auto-populate if the corresponding Nursing Facility Case Management, Acute Care Hospital or State Hospital Screen has been completed.
iv. Enter the *Estimated Discharge Date* to indicate when the client is expected to transition back to the community. This date is an estimate and does not need to reflect the client's actual discharge date.
v. Complete SER note of the re-enrollment.

Upon transition, follow all other instructions regarding transitioning from an institution including entering all the required information on the Enrollment screen and NFCM screen (if applicable) in CARE.

When in doubt, send questions and concerns to:
HCS: DSHSALTSARCLReferrals@dshs.wa.gov
DDADDA: ddarclenrollmentintake@dshs.wa.gov
HQ RCL Staff are happy to help!

What is the procedure for RCL participants who have received services but who choose not to receive personal care services in the community?

In order for participants to remain on the RCL program for the full 365 days post institutional transition, they must accept an RCL paid service from the RCL community transition and sustainability package of services. For those HCS participants who choose to decline all paid services in addition to declining personal care services, follow the Termination of Services guidelines and procedures as outlined in Chapter 5: Case Management. In addition, formally disenroll the participant from RCL by updating the RCL Enroll/Disenroll screen in CARE following all disenrollment steps. DDADDA RCL participants will remain active on DDADDA caseload for the full 365 days and then transition to the non-paid services caseload after their demonstration year.

Can RCL participants choose not to participate in the RCL project?

HCS/AAA/DDADDA: Yes. When a participant or their representative wants to withdraw from the RCL project, work with the participant to resolve issues, if possible. If the participant still wishes to disenroll in RCL but wants to continue to receive state plan or waiver services, a CARE assessment and financial eligibility determination must be completed to establish the participant's eligibility for the appropriate Medicaid waiver or state plan program.

RCL services for all participants must end by day 366 (on or before day 365). At that time, they must be transitioned to the waiver or state plan services available to them based on their financial and functional eligibility.

Actions to prepare for the end of the RCL 365 day service period

The *Projected End Date* displayed on the RCL enroll disenroll screen in CARE indicates the end of the individual's RCL participation period. Approximately 60 days prior to the end of the individual's 365 day service year, the CM/CRM/CNC should check in with the RCL participant and ensure the client continues to be stable in their community setting. This is an important period of time to determine if the client is in need of any of the RCL package of services prior to the demonstration year ending. Does the client require an updated assessment? If so, follow usual assessment procedures. Ensure that any necessary steps are taken in order for the participant to maintain successful community living, including an evaluation of functional and financial program eligibility for services after the participant's 365 day demonstration period has expired. To complete RCL disenrollment steps at the end of the participation period, see Individual has completed 365 days of RCL participation period.

NOTE: The assessment may be moved to Current prior to the end of the 365 day demonstration period. However, in order to maximize the enhanced match received for RCL services, end date the RCL RAC to match the Projected End Date on the RCL Enroll/Disenroll screen and open the new RAC identifying the on-going service program(s) starting the day after the RCL Projected End Date. The RCL RAC should be assigned for the maximum length of time based on the Projected End date which considers any disenrollments and re-enrollments which pushed the Projected End Date out beyond the original 365 days (you can use a custom tickler as a reminder to change the RAC at the appropriate time). When ending the RCL RAC and starting the on-going program(s) RAC mid-month, this action may require modifying/splitting of the service payment line, please review P1 Social Services Manual for procedure steps.

RCL DISENROLLMENT ACTIONS FOR HCS, AAA AND DDADDA

RCL disenrollment reasons:

An individual must be disenrolled from RCL for the following reasons:

- **Chose an unqualified setting (with AFH, PACE, RSW, SDCP, etc):** Select this reason when the individual transitions to any of the listed unqualified settings whether upon initial transition from the institution or at any point during their RCL participation period in the community.
    - If the individual is transitioning directly to an unqualified setting from an institution, refer to What is the process of disenrolling an individual from RCL who is still in an institutional setting? for disenrollment steps.
    - If the individual is currently living in the community and will be transitioning to an unqualified setting, see Disenrollment when an individual has chosen an unqualified setting for required steps.
- **Deceased:** Select this reason when the client has passed away.
    - If the individual passed away while in an institutional setting, refer to What is the process of disenrolling an individual from RCL who is still in an institutional setting? for disenrollment steps.
    - If the individual passed away while in the community, refer to Disenrollment after an individual has passed away for steps.
- **Has completed 365 day participation period**: Select this reason once a client has completed their 365-day participation period. The case manager will know when the client has completed their 365-day participation period by looking at the *Projected End Date* listed on the RCL enroll disenroll screen in CARE. The case manager will also receive Ticklers when the participant has 60,30 and 5 days left on their RCL participation period. When selecting this disenrollment reason, the disenrollment date should match the projected end date. There are several actions the case manager must complete before the participant's RCL participation period ends. See, Actions to prepare for the end of the RCL 365 day service period.
    - For disenrollment steps, refer to Disenrollment steps once an RCL participant has completed 365 day participation period.

- **Moved out of WA:** Select this reason if a client has moved out of Washington State. There are others states and territories that participate in the Money Follows the Person (MFP) federal demonstration program. Click here for a current list of MFP states/Project Directors. For disenrollment steps, refer to Disenrollment when an individual who has moved out of WA.
- **No longer Medicaid eligible:** Select this reason if a client is no longer Medicaid eligible. This might include a client who is incarcerated and can no longer receive Medicaid. If a client is no longer financially eligible, please reach out to the HQ RCL team as there are specific financial eligibility considerations for RCL enrolled individuals. Refer to Disenrollment when no Longer Medicaid Eligible for disenrollment steps.
- **No longer wants RCL services:** Select this reason if an individual has chosen to stay long term in the institutional setting or if a client withdraws from all services after transition to the community.
  - If the client is remaining in the institutional setting, see What is the process of disenrolling an individual from RCL who is still in an institutional setting? for disenrollment steps.
  - If the client withdraws from all services after transition (within their RCL participation period), see No longer wants RCL while living in community-based setting for disenrollment steps.
- **Reinstitutionalized for greater than 30 days**: Select this reason when a client has been reinstitutionalized for more than 30 days. This will pause the "RCL clock" and allow the individual to continue to access RCL services to support a return to the community when a subsequent enrollment is made. Do not use this reason if the client has been reinstitutionalized for less than 30 days. For disenrollment steps, see If a participant is re-admitted into an institutional setting.

Steps to disenroll a participant from RCL:

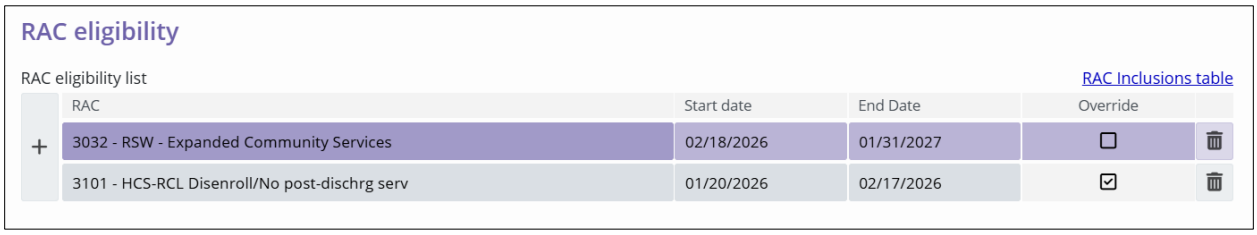
The actions required of the HCS, AAA, or DDADDA CM/CRM during disenrollment vary based on the reason for disenrollment. Detailed steps for each scenario are provided below.

Disenrollment when an individual has chosen an unqualified setting while in the community

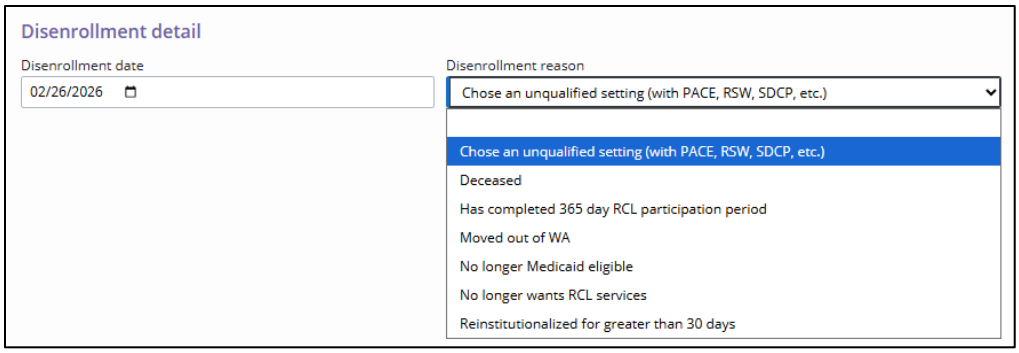
Note: If an individual is being disenrolled from RCL because they are transitioning directly from an institutional setting into an unqualified setting, refer to What is the process of disenrolling an individual from RCL who is still in an institutional setting?

If an individual currently living in the community and has now chosen an unqualified RCL setting (AFH, PACE, RSW, SDCP, etc.), the CM/CRM must follow these steps:

1. End date of the RCL RAC (HCS 3100 or DDA 3701), for the date prior to the client converting to an unqualified RCL setting, and add the ongoing applicable state plan/waiver HCBS RAC the individual is eligible to receive based on functional and financial eligibility.
   Note: For PACE, refer to LTC Manual Chapter 29c: Program of All-Inclusive Care for the Elderly



2. Add the Disenrollment Date to the RCL Enroll/Disenroll screen in CARE. This date must match the RCL RAC end date.
3. Choose "Chose an unqualified setting (with PACE, RSW, SDCP, etc.)" as the Disenrollment Reason in CARE. **Note:** Although AFH is not listed, it is considered an unqualified setting.



4. Follow instructions as outlined in Chapter 3: Assessment and Care Planning to obtain approval of the plan of care, send all required documents/forms to the individual, representatives and providers (including PANs), and complete required documentation of these activities.

5. For **Classic Medicaid participants**, Notify the PBS on a DSHS 14-443 (for HCS/AAA) or a DSHS 15-345 (for DDADDA) in Barcode and include:
   a) The date of the disenrollment from RCL services.
   b) The program the participant is functionally eligible for (state plan/Medicaid waiver), and this program start date.
   c) The setting of the services (in-home, ALF, etc.).
   d) Update the address, if necessary.

   For individuals who are managed Medicaid and enrolled with a Managed Care Plan (also known as the MAGI, ABP or MCS group), additional steps must occur as part of transition planning for the end of the RCL 365 day service period.
   - 90 days prior to the end of the 365 day demonstration year, begin pursuing a disability determination, if enrolling the individual onto a waiver program (i.e., COPES, New Freedom, Basic +, Core, Community Protection, or CIIBS) or prepare to transition the client to ABP-CFC only.
   - 60 days prior to the end of the 365 day demonstration year: If the RCL client is utilizing waiver services or is wishing to access Waiver services after RCL expires, assist the client

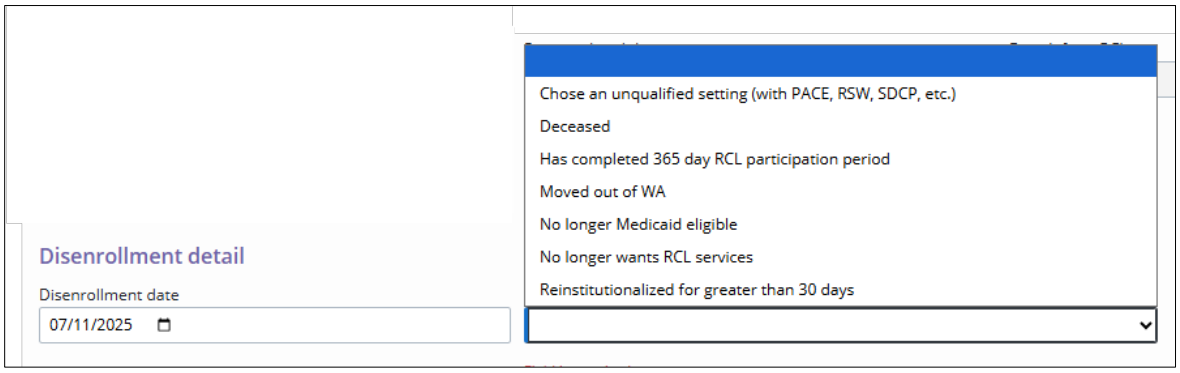
with submitting a LTSS application for a financial determination of waiver services (i.e., COPES, New Freedom, Basic +, Core, Community Protection, or CIIBS).
- 30 days prior to the end of the 365-day service period, the case worker should review eligibility status with the Public Benefits Specialist.

Public Benefits Specialists must follow instructions as outlined in the *Apple Health Medicaid Manual*.

Disenrollment after an individual has passed away

Note: If completing the disenrollment while the individual is still in the institutional setting, refer to What is the process of disenrolling an individual from RCL who is still in an institutional setting? for disenrollment steps.

1. End date the RCL RAC matching the date of death
2. Enter the same date for the *Disenrollment Date* on the RCL enroll/disenroll screen in CARE. **Do not enter an *Actual Discharge Date.***
3. Select "Deceased" for the *Disenrollment Reason*



4. Follow the Termination of Services guidelines and procedures as outlined in Chapter 5: Case Management.

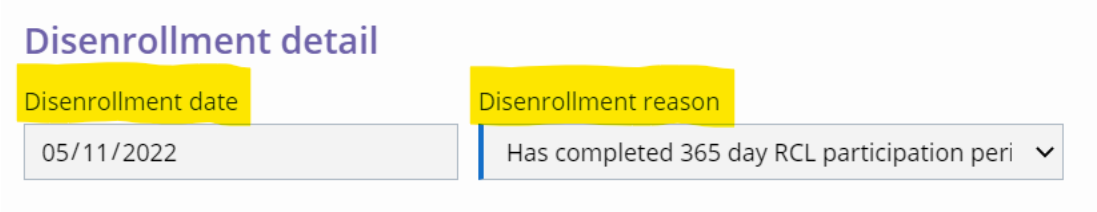
Disenrolling steps once an RCL participant has completed 365 days of RCL participation period

Reminder: The Projected end date listed on the RCL Enroll/Disenroll screen in CARE indicates the end of the participant's 365 day demonstration period.

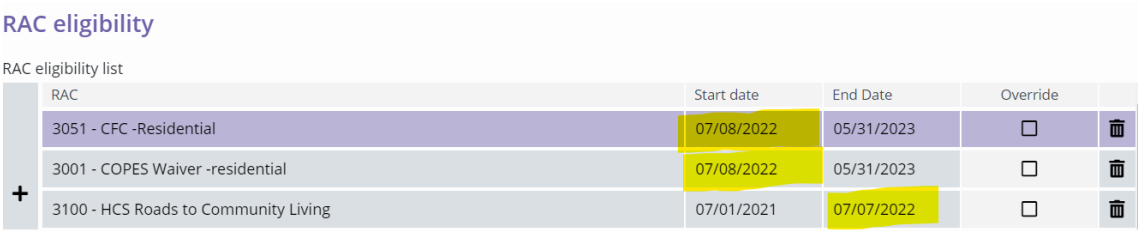
1. Add the Disenrollment Date to the RCL Enroll/Disenroll screen in CARE. This date should match the Projected end date listed on the RCL Enroll/Disenroll screen.
    - **Note:** Case managers have flexibility in entering the RCL disenrollment date as the last day of the previous month. For example, if the Projected end date is 5/11/22, a case manager can enter a disenrollment date of 4/30/22. The RCL RAC must also reflect the same end date. The Disenrollment reason of "Has completed 365 day RCL participation period" is still chosen.

- A client's projected end date may extend beyond the current plan period. RCL should be maintained through the full projected end date, even when it overlaps with multiple plan periods.

2. Chooses "Has completed 365 day RCL participation period" as the Disenrollment Reason in CARE



3. Ensures the end date of the RCL RAC (HCS 3100 or DDA 3701) matches the Disenrollment Date and adds the on-going applicable state plan/waiver HCBS RAC the individual is eligible to receive based on functional and financial eligibility (see **Note** above).



4. Follow instructions as outlined in Chapter 3: Assessment and Care Planning to obtain approval of the plan of care, send all required documents/forms to the individual, representatives and providers (including PANs), and complete required documentation of these activities.

5. For Classic Medicaid participants, Notify the PBS on a DSHS 14-443 (for HCS/AAA) or a DSHS 15-345 (for DDADDA) in Barcode and include:
   e) The date of the disenrollment from RCL services.
   f) The program the participant is functionally eligible for (state plan/Medicaid waiver), and this program start date.
   g) The setting of the services (in-home, ALF, etc.).
   h) Update the address, if necessary.

   For individuals who are managed Medicaid and enrolled with a Managed Care Plan (also known as the MAGI, ABP or MCS group), additional steps must occur as part of transition planning for the end of the RCL 365 day service period.
   - 90 days prior to the end of the 365 day demonstration year, begin pursuing a disability determination, if enrolling the individual onto a waiver program (i.e., COPES, New Freedom, Basic +, Core, Community Protection, or CIIBS) or prepare to transition the client to ABP-CFC only.
   - 60 days prior to the end of the 365 day demonstration year: If the RCL client is utilizing waiver services or is wishing to access Waiver services after RCL expires, assist the client

with submitting a LTSS application for a financial determination of waiver services (i.e., COPES, New Freedom, Basic +, Core, Community Protection, or CIIBS).

- 30 days prior to the end of the 365-day service period, the case worker should review eligibility status with the Public Benefits Specialist.

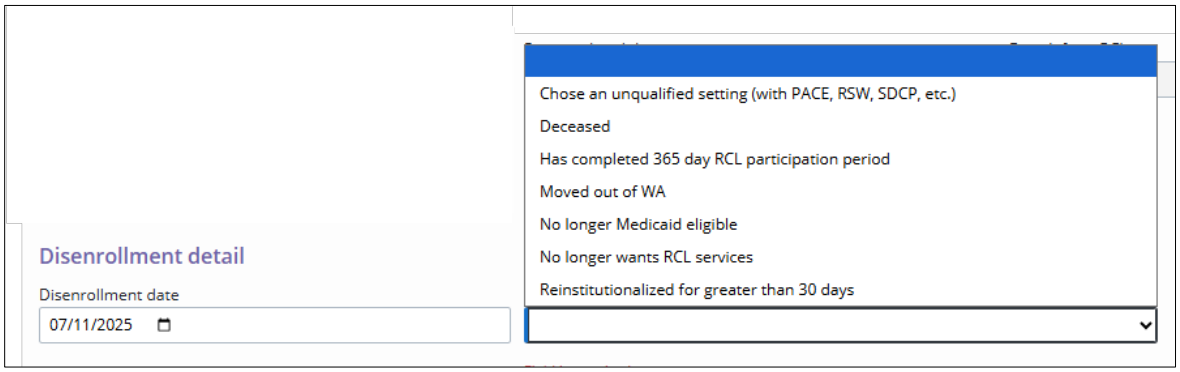
Public Benefits Specialists must follow instructions as outlined in the *Apple Health Medicaid Manual*.

When in doubt, send questions and concerns to:
HCS: DSHSALTSARCLReferrals@dshs.wa.gov
DDADDA: ddarclenrollmentintake@dshs.wa.gov
HQ RCL Staff are happy to help!

Disenrollment when an individual has moved out of WA

Note: If the individual moved out of Washington State directly from the institutional setting to a home and community-based setting, enter the ***Actual Discharge Date*** and additional fields that auto-populate in the RCL enroll/disenroll screen in CARE. If the individual is already living in the community, an *Actual Discharge Date* will have already been entered.

1. End date the RCL RAC to correspond with the date of move
2. Enter the same date for the *Disenrollment Date* on the RCL enroll/disenroll screen in CARE.
3. Choose the appropriate *Disenrollment Reason*



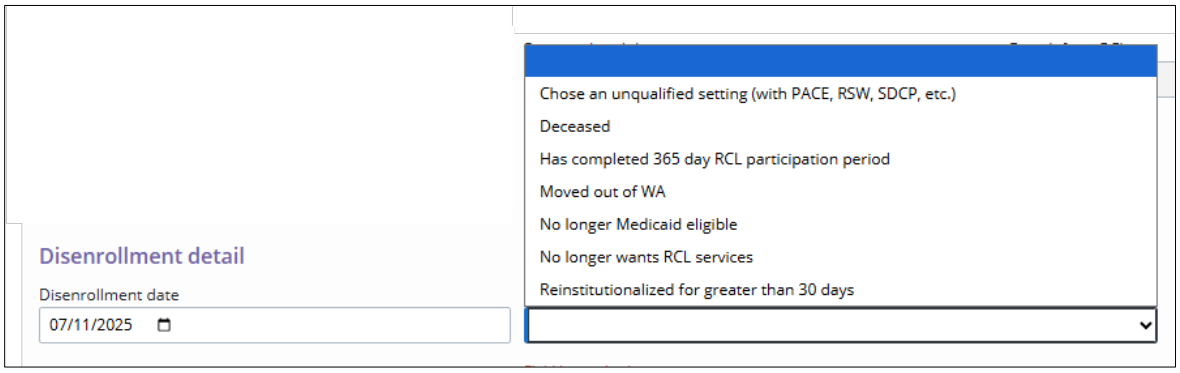
4. Follow the Termination of Services guidelines and procedures as outlined in Chapter 5: Case Management.

Disenrollment when the individual is no longer Medicaid eligible

If the client is no longer Medicaid eligible and still in an institutional setting, refer to What is the process of disenrolling an individual from RCL who is still in an institutional setting? for disenrollment steps.

For a client living in a community-based setting who is no longer financially eligible, please email the HQ RCL Policy Unit as there are specific financial eligibility considerations for RCL enrolled individuals. Email HCS: DSHSALTSARCLReferrals@dshs.wa.gov or DDADDA: ddarclenrollmentintake@dshs.wa.gov.

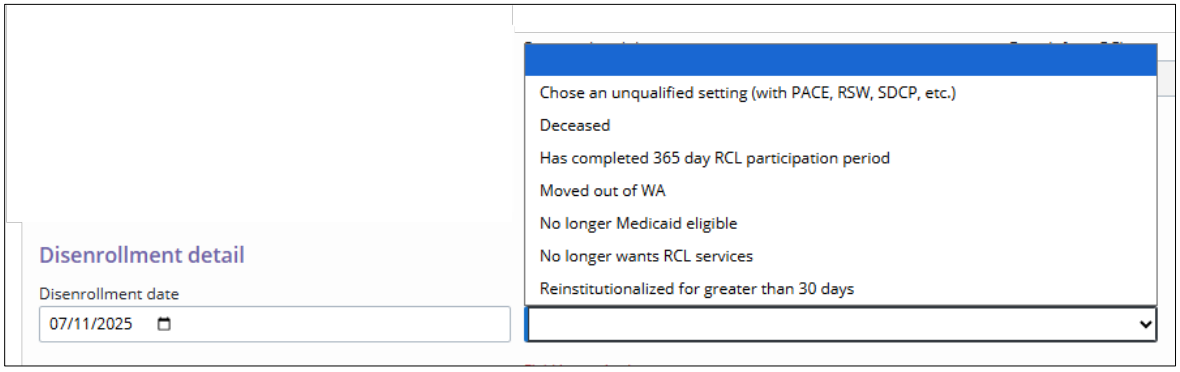
1. End date the RCL RAC to correspond with the date of move
2. Enter the same date for the *Disenrollment Date* on the RCL enroll/disenroll screen in CARE.
3. Choose the appropriate *Disenrollment Reason*



4. Follow the Termination of Services guidelines and procedures as outlined in Chapter 5: Case Management.

Disenrolling an individual who no longer wants RCL services while in a community-based setting

1. End date the RCL RAC to correspond with the date of move
2. Enter the same date for the *Disenrollment Date* on the RCL enroll/disenroll screen in CARE.
3. Choose the appropriate *Disenrollment Reason*



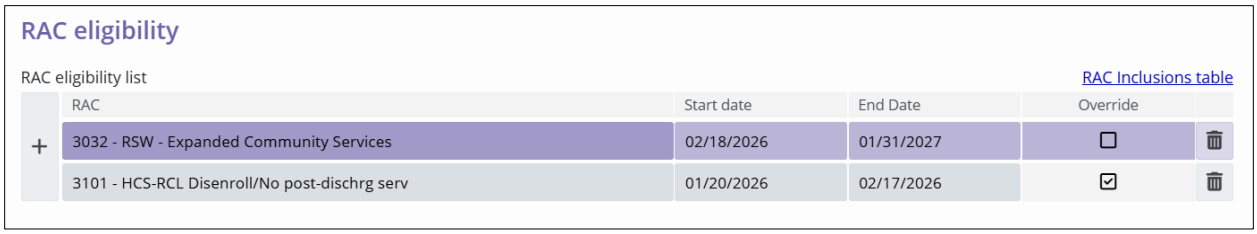
4. Follow the Termination of Services guidelines and procedures as outlined in Chapter 5: Case Management.

What is the process of disenrolling an individual from RCL who is still in an institutional setting?

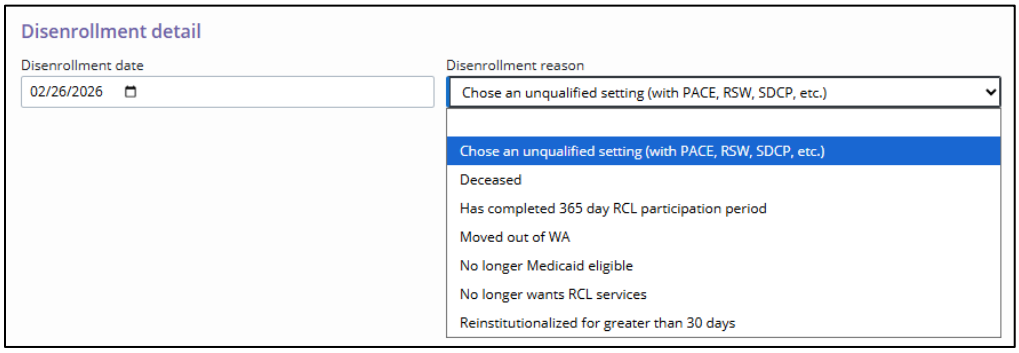
If an individual no longer plans to transition on RCL, passes away prior to transition, or transitions directly to an RCL unqualified setting (AFH, RSW, SDCP, PACE, etc.) from the institution, the individual must be disenrolled from RCL and RAC changes are needed.

If the RCL enrolled individual is transitioning directly to an unqualified setting from the institution:

1. End date the RCL RAC one day prior to discharge. For example, if the date of discharge is 2/18/26, end date the RCL RAC 2/17/26.
2. Add the ongoing applicable state plan/waiver HCBS RAC the individual is eligible to receive based on functional and financial eligibility.



3. Enter the *Disenrollment Date* to the RCL Enroll/Disenroll screen in CARE. This date must match the RCL RAC end date. **Do not enter a date in the *Actual Discharge Date* field.**
4. Select "Chose an unqualified setting (with PACE, RSW, SDCP, etc.)" as the *Disenrollment Reason* in CARE.
   Note: Although AFH is not listed, it is considered an unqualified setting.



5. **For HCS clients**: Email DSHSALTSARCLReferrals@dshs.wa.gov to notify the HQ RCL Policy Unit of the disenrollment so RAC changes can be completed.
   - For HCS: RAC 3100 – HCS RCL Roads to Community Living must be replaced with 3101 – HCS-RCL Disenroll/No post-discharge services.
6. For DDADDA Clients: The DDADDA CRM will replace the RAC 3701 – DDA Roads to Community Living with 3702 DDA- RCL Disenroll/No post discharge services.
7. Follow instructions as outlined in Chapter 3: Assessment and Care Planning to obtain approval of the plan of care, send all required documents/forms to the individual, representatives and providers (including PANs), and complete required documentation of these activities.

Prior to discharge, if an individual has passed away or is no longer planning to transition to the community:

1. End date the RCL RAC.
2. Enter the *Disenrollment Date* on the RCL enroll disenroll screen using the same end date as the RCL RAC. **Do not enter a date in the *Actual Discharge Date* field.**

3. **For HCS clients**: Email DSHSALTSARCLReferrals@dshs.wa.gov to notify the HQ RCL Policy Unit of the disenrollment so RAC changes can be completed.
    - **For HCS**: RAC 3100 – HCS RCL Roads to Community Living must be replaced with 3101 – HCS-RCL Disenroll/No post-discharge services.
4. **For DDADDA clients**: The DDADDA CRM will replace the RAC 3701 – DDA Roads to Community Living with 3702 DDA- RCL Disenroll/No post discharge services.
5. Follow the Termination of Services guidelines and procedures as outlined in Chapter 5: Case Management.

What about Contracting?

All LTC contracts are executed through the AAA unless other local agreements are in place that state otherwise. RCL services are contracted utilizing the same procedures as other client service contracts. Obtain a list of current contracted providers from your local AAA office. Notify your regional HCLA HQ Resource and Development team member and/or local AAA Contract Managers if you find there is a network capacity need for contracted providers in your area.

For DDADDA contracts, refer to the DDADDA RCL Coordinator with questions.

Note: In addition to specific contracted duties, each provider is responsible for reporting any instances of abuse, neglect, or exploitation of a vulnerable adult or child.

Note: All IPs must be currently employed with Consumer Direct Care Network (CDWA) before becoming a paid provider for a participant who is being served in the RCL project.

How is the project evaluated?

The Centers for Medicare and Medicaid Services (CMS) requires regular reports on RCL participants in their demonstration year. In addition, CMS evaluates grantees semi-annual reporting to monitor progress and identify challenges and improvement opportunities with participating state's MFP programs.

RESOURCES

Money Follows the Person Tribal Initiative

The MFP Tribal Initiative focuses on developing inclusive service contracts and engaging potential partners at the state, tribal and county levels for improved and culturally inclusive service delivery of ALTSA services, including tribal contracted support services. The initiative's goals are to:

- Identify American Indians/Alaska Natives (AI/AN) who are living in institutions and assist them to return to their community of choice.

- Develop culturally inclusive service systems and providers to support American Indians/Alaska Natives once they returned to their communities.
- Support tribal contracts to provide long-term services and supports.

Information about the Money Follows the Person RCL Project

Public HCS website: Roads to Community Living (RCL) | DSHS (wa.gov)
Public DDADDA website: Roads to Community Living | DSHS (wa.gov)
Public TI website: Money Follows the Person Tribal Initiative | DSHS (wa.gov)
Federal website: Money Follows the Person | Medicaid

WAC 388-106-0250-0265

RCL Enrollment Form (managed by HCS HQ)

RCL Enrollment Form

Client Services Purchasing Card Process (HCS Only):

HCS Purchasing Card

DMS Packet Cover form:

02-615 Social Services Packet Coversheet General Utility & Repair Allowance form:

Form 27-147 Community Choice Guide Activity Tracking Form:

CCG Activity Tracking Form - Instructions and Samples
CCG Activity Tracking Form MONTHLY
CCG Activity Tracking Form WEEKLY

What Program to Use: Transition and Sustainability Goods and Services:

Which Program to Use Transition and Sustainability Goods and Services

Technology Support Consultation and Technical Assistance Desk Aid:

Desk Aid for Technology Support Consultation

Smart Care Device Desk Aid:

RCL Desk Aid for Smart Care Device
Smart Care Device Suitability Guide for ElliQ

Non-Medical Transportation Request Process
Non-Medical Transportation Request Process
Medstar Trip Request Form
Medstar Stretcher Transport Form

HCS Decision Making for Transitions/Authorized Representative

HCLA Power of Attorney vs. Uniform Guardianship HCLA How to Identify a Guardian HCS Decision Making for Transitions.pdf

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
07/2026	Rebecca Kaiser Desiree Vallejo	• Updated all references of DDCS to DDA • Added reference to Room and Care procedure for CCG residential searches.	
05/2026	Samantha Dunham Desiree Vallejo Cassie Pizano	• Removed references to Adult Family Homes as RCL qualified settings. • Clarified the use of RCL services to support individuals who are still institutionalized but planning to transition to an RCL unqualified setting. • Clarified what CCGs are not permitted to do and outlined the steps for referring and authorizing CCG services. • Expanded the Client Training-Behavior Support service details to align with the COPES chapter. • Updated and added guidance on determining which program to use for transition and sustainability goods and services • Removed the Emergency Rental Assistance (ERA) section as it is no longer offered under RCL • Added details for the Pantry Stocking service • Added a link to desk aid for referring and authorizing Technology Support Consultation and Technical Assistance • Clarified disenrollment reasons and procedures • Updated Smart Care Device name and eligibility • Updated Assistive Technology (AT) section to align with CFC Chapter • Updated (RCL) Smart Care Device Desk Aid	
11/2025	Samantha Dunham Desiree Vallejo	• Updated CCG Service Codes descriptions & Tracking forms to be aligned with contract updates. • Updated to include all RCL services and added hyperlinks to Service Code Data Sheets • Clarified eligibility requirements for individuals in inpatient psychiatric hospitals	

6/2025	Samantha Dunham Cassie Pizano	• Updated all references of ALTSA to HCLA and DDA to DDA • Updated end dates of RCL demonstration project • RCL eligibility clarified to indicate 60 day stay can include multiple institutional settings • Clarified enrollment request instructions • Provided examples of client situations which Client Training: Behavior Support Services may be beneficial • Added clarification to Community Choice Guide (CCG) scope of work • Added clarification on next steps when disenrolling RCL participant due to completing 365 day demonstration period • Added clarification on next steps when client is reinstitutionalized • Updated disenrollment reasons to include "No Longer eligible for Medicaid" and updated RCL enroll/disenroll screen shot • Updated Smart Care Companion Desk Aid link	
03/2025	Samantha Dunham Cassie Pizano Desiree Vallejo	• Corrected end dates of RCL demonstration project • Added clarification regarding fast track and RCL • Added clarification on process to authorize Client Training: Behavior Support Services • Added clarification that Community Transition Services – Items does not permit payment of tips. • Added MIST information • Added Smart Care Companion service information • Added 14-225 and 16-472 as necessary forms to be completed upon authorizing RCL services for HCS clients • Updated treatment names for Community Transition Goods/Items, Community Transition Services and Short-Term Rental Assistance • Added the process to disenroll an individual from RCL prior to discharge • Added Money Follows the Person Tribal Initiative information and website • Updated PAN example	

10/2024	Samantha Dunham	• Provided clarification on RCL demonstration year and CARE Plan period misalignment. • Added Public RCL Website links for DDA and HCS	
7/2024	Samantha Dunham	• Revised the format of the chapter to outline eligibility prior to RCL service descriptions. • Provided clarification on concurrent authorization of SA263 and SA266. • Included RCL services PAN screen shot example. • Added CCG Activity Tracking form to Resources Section. The Form includes the option for providers to submit the form directly to the Imaging Unit via fax.	
4/2024	Julie Cope	• Included form of 27-147A for General Utility and Repair Allowance. • Added Description of Technology Support Consultation and Technical Assistance service (H2014 U9) • Added Service Code Data Sheet links for Pantry Stocking (SA420-U1) • Included additional direction for NFLOC communication for RCL enrolled participants of MAGI or MCS Medicaid programs into ProviderOne.	H24-018
11/2023	Amanda Speck	• Clarification on SA266 Purchasing and CCG reimbursement timeliness. • Included additional service information for: Trial Visits, Pantry Stocking & Non Medical Transportation • Amendment of SA297, SA296 and Environmental Modification service code purchase limits without ETR.	H23-090
08/2023	Stephanie VanPelt	• Added Emergency Rental Assistance information • Added P-card information and guide • Added Environmental Modification General Utility Allowance information • Updated RCL project dates • Updated DMS packet cover form 02-615	H23-071
09/2022	Stephanie VanPelt	Included RCL Referral shared email box Removed detailed description of RCL eligible settings. Updated RCL enrollment/disenrollment instructions to reflect CARE Web migration Aligned RCL case management and transfer procedures with the State Plan and Chapter 5.	H22-042
5/2022	Stephanie VanPelt	Extended RCL Project through 12/31/2026	H22-028

06/2021	Stephanie VanPelt	• Updated RCL qualified and unqualified community settings. • Updated RCL eligibility criteria from 90 days to 60 days continuous qualified institutional stay. • Addition of Residential Unit Furnishings WACs and guidance	H21-050
03/2021	Stephanie VanPelt	• The RCL project has been extended through 12/31/2022 • Updated language in the eligibility section to reference the state funded non-citizens medical benefit instead of the acronym AEM and updated language related to PACE program	H21-018
8/2020	Stephanie VanPelt	Updated RCL Expert Contact information Clarified Services available to RCL Participants Added CCG Tracking Forms in Resource Section	H20-031