Residential Support Waiver (RSW)

Chapter 7f describes the Residential Support Waiver (RSW), a home and community-based services (HCBS) program approved by the Centers for Medicare and Medicaid in 2014 under the 1915c waiver authority. RSW is designed to support eligible individuals with personal care and behavior support services in residential settings.

Ask the Experts

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BACKGROUND

WHAT IS THE RESIDENTIAL SUPPORT WAIVER (RSW)?

The RSW is one of the 1915(c) Medicaid waivers operated by Home and Community Living Administration's (HCLA) Home and Community Services (HCS). This waiver provides the opportunity for individuals who, in the absence of the home and community-based services and supports provided under RSW, would otherwise require the level of care furnished in a nursing facility or other institutional setting.

RSW services are designed for eligible Clients who require support from caregiving staff who have completed specialized training in providing personal care, crisis response techniques, and are able to implement proactive behavioral supportive interventions developed by a community behavior support services provider.

Many Clients receiving RSW services have, historically, not had the support they needed to safely remain in other community residential settings. In order to provide a stable residential home environment, RSW Clients often have primary or co-occurring neurocognitive, substance use, or traumatic brain disorder which require an array of behavioral health support both through the RSW and as coordinated with the state plan and other community services.

The RSW serves Clients who are either returning to the community from state or community psychiatric hospitals, have had a single or multiple unsuccessful community residential settings, or are at risk of losing their current community residential setting due to behavioral challenges.

Non-RSW Behavior Support Services

Expanded Behavior Support

- Please see LTC Manual Chapter 10 Nursing Facility Case Management and Relocation for more information on EBS or EBS-Plus in a skilled nursing facility.

COPES Client Training-Behavior Support

- **Please see LTC Manual Chapter 7d: COPES**
- **H2019 Behavior Support – Individual**

WHO IS ELIGIBLE FOR RSW?

To be eligible for the RSW program, and before services can be authorized, the Client must meet **ALL** of the following eligibility criteria:

Functional Eligibility:

- Age 18 or older & blind or has a disability as outlined in WAC 182-512-0050; or is
- Age 65 or older

- CARE algorithm determines that the individual meets nursing facility level of care as outlined in WAC 388-106-0355(1), WAC 182-515-1506;
- CARE algorithm determines that the individual meets RSW eligibility as outlined in 388-106-0388 when the following 5 questions are answered" yes" or" no":

1. Is the Client currently admitted to a state mental or psychiatric unit of a hospital and is deemed ready for discharge?

2. Does the Client have a history of frequent and repeated episodes of destabilization resulting in loss of services, homelessness, hospitalization or incarceration?

3. Does Client have a history of an inability to remain medically or behaviorally stable for a period of longer than six months?

4. Has the Client exhibited behaviors or uncontrolled symptoms and has an unmet need for supportive interventions?

5. Has the Client demonstrated difficulty managing medications, which has affected their ability to live in the community?

Note: you will notice that the WAC 388-106-0338 and the RSW CARE Eligibility Questions don't match word for word. That's okay. Answer the question in CARE as they are written in CARE. The Help Screen has been updated to help you answer the questions. If you are unsure, please reach out to your direct supervisor.

Financial Eligibility:

Case Managers should confirm financial eligibility requirements listed below:

- Meet the Supplemental Security Income (SSI) disability criteria; and
- Be eligible for institutional categorically needy (CN) medical coverage group.

Note: Per LTC Manual Chapter 7a Financial Eligibility for Core Programs, MAGI-based medical coverage groups are not eligible for HCBS waiver services (including the RSW) , though they may apply, and be related to SSI via a non-grant medical assistance (NGMA) determination (a disability / blindness determination).

See Chapter7a of the LTC manual for more information regarding financial eligibility for LTC programs.

Acknowledgement of Services—Documenting Client Consent

Clients who are functionally and financially eligible for the waiver services can choose to receive their care in an institution or in the community. If the individual is choosing RSW, they will be choosing to receive their care in the community. CMs must complete the Acknowledgment of Services form (DSHS 14-225) to document that the program choices have been explained to the Client and the Client has acknowledged their choice of waiver services over nursing facility care. This form is a federal

requirement, and **waiver services cannot be authorized without the Client's signature on the Acknowledgment of Services form (DSHS 14-225).** The Case Manager must submit the original to DMS and provide the Client with a copy of the form for their records.

If a waiver Client enters a nursing facility for less than 30 days, waiver services cannot be provided during the time the Client is in the nursing facility. The end date for all waiver service authorizations must be changed to match the admission date into the nursing facility. However, enrollment on the waiver is not terminated and eligibility does not have to be re-determined when returning to the community. A new DSHS 14-225 is not required if the stay is short term (less than 30 days).

If a waiver Client enters a nursing facility for 30 days or longer, waiver services are terminated, and the Client is dis-enrolled from the waiver. The Client must have their eligibility re-established if he/she re-enters the community on waiver services. A new DSHS 14-225 is required when the Client returns to the community after a stay of 30 days or more in the nursing facility.

Federal rules require that waiver services not replace other services that can be accessed under Medicaid, Medicare, health insurance, Long Term Care (LTC) insurance, and other community or informal resources available to them.

- If a Client has other insurance or resources, case managers must document the denial of benefits before the Client can access waiver services. This documentation must be in the Client's file.
- Waiver services may not be used when the vendor refuses the reimbursement or considers the payment inadequate from the other resources.
- Waiver services may not supplement the reimbursement rate from other resources.
- ETRs are not allowed for the above circumstances.
- Waiver services may not supplement the reimbursement rate from other resources.
- ETRs are not allowed for the above circumstances.

For more information about acknowledgement of services including form DSHS 14-225, see LTC Manual Chapter 3: Assessment and Care Planning.

WHERE CAN INDIVIDUALS RECEIVE RESIDENTIAL SERVICES UNDER THE RSW?

RSW services are available in contracted Adult Family Homes (AFH), Assisted Living Facilities (ALF), Enhanced Adult Residential Care (EARC) facility, and Enhanced Services Facilities (ESF).

Residential Settings	Expanded Community Services (ECS)	Specialized Behavior Support (SBS)	Community Stability Supports (CSS)	Enhanced Services Facility (ESF)

Adult Family Home (AFH)	Yes, with ECS Contract	Yes, with SBS Contract	No	No
Assisted Living Facility (ALF)	Yes, with ECS Contract	No	Yes, with CSS Contract	No
Enhanced Services Facility (ESF)	No	No	No	Yes, with ESF Contract

SERVICES AVAILABLE THROUGH THE RSW

Clients who meet functional and financial requirements for the Residential Support Waiver may receive the following RSW services:

Expanded Community Services (ECS)

Offered in:

- Adult Family Homes with an ECS contract
- Assisted Living Facilities and Enhanced Adult Residential Care (EARC) facilities with an ECS contract.

In collaboration with:

- An ECS-contracted Community Behavior Support Provider

What services are available under ECS?

- Personal care;
- 24-hour on-site support and response staff;
- Medication management; and
- Behavior Support Services
- An RSW Client and the residential provider work in coordination and collaboration with a contracted behavior support provider to develop and implement an individualized Behavior Support and Crisis Plan (BSCP).

ECS Provider Qualifications and Responsibilities

AFH/ALF/EARC Residential Provider Qualifications

- Be an official AFH/ALF/EARC licensee with the State of Washington for twelve (12) months or more.
- Have had no significant enforcement actions, as determined by a review of the enforcement history, during the twelve (12) months preceding

AFH/ALF/EARC Residential Provider Responsibilities

- Coordinate the delivery of Behavior Support Services with an appropriate Behavior Support Provider who has a contract with DSHS to provide ECS;
- Prepare for and facilitate Behavior Support Services that will be provided in the AFH and will include training provided to or on behalf of specific ECS Clients in order to support each ECS Client's ability to remain in the community.
- Identify an ECS team for each ECS Client. The ECS team will include, but not be limited to the ECS Behavior Support Provider, facility staff and other professional staff involved with the ongoing care of the Client.
- Coordinate facility team meetings at least once a month for each ECS Client.
    - The Residential provider shall ensure facility staff attend the meetings and participate in the development of the Behavior Support Plan for each ECS Client. The Behavior Support Plan shall be incorporated into the ECS Client's Service Plan and NCP or NSA.
- Coordinate opportunities for staff and ECS Clients to receive training that supports each ECS Client. Training provided shall range from broad behavioral care topics to specific consultation and training related to the needs of the ECS Client. The training may be provided in cooperation with the Behavior Support Provider
- Collaborate with the Behavior Support Provider to develop a written Behavior Support and Crisis Plan (BSCP) to respond to identified ECS Client indicators of potential crisis.
    - The goal of the BSCP is to develop interventions to prevent and respond to crises. The program strategy shall include specific courses of action to respond to the needs of the ECS Client.
        - It will also describe the mechanisms that will be used to document facility staff training for each Behavior Plan.
        - The BSCP strategy shall be developed cooperatively with appropriate parties. If the Client's physical or behavioral status changes significantly, the Provider shall immediately notify the HCS Social Worker and the Behavior Support Provider.
        - The BSCP will be incorporated into the Client's NCP or NSA.

Contracted Behavior Support Provider Qualifications

- **Have a current ECS contract**
- **Have the required professional staff to fulfil the ECS Contract**

The contracted behavior support provider will provide a team of professionals experienced in behavioral health interventions (herein referred to as Behavior Support Team) to provide specialized formal and informal training and consultation on behavior management to or on behalf of HCLA Clients who have been authorized to receive ECS.

Behavior Support Team must consist of:

- A **prescriber** licensed by the state of Washington as either a Psychiatrist, Psychiatric ARNP, a Physician's Assistant (PA) with at least two (2) years' experience in working with adults who have exceptional long-term care needs due to a combination of medical and behavioral issues, or a Registered Pharmacist or Pharmacist D (Pharm D) who works under the oversight of a Psychiatrist or ARNP.

- **Behavior Support Clinician:** Is a licensed or certified psychiatric nurse, mental health professional, or board-certified behavior analyst with two years' experience working with adults who have exceptional long-term care needs due to a combination of medical and behavioral issues. Staff with at least a bachelor's degree in a related field, who are working toward becoming a mental health professional, may provide services as a clinician under the direction of a licensed behavior analyst.

- **Certified Peer Counselors (CPC)** In addition to the certified professionals, a Provider may also choose to include a Washington State Certified Peer Counselor (licensed per WAC 182-115-0100 through December 31, 2026) to provide community integration, activity support/development, encouragement and resources to the Clients served in this Contract. On January 1, 2027, the profession of certified peer support specialist, as defined in RCW 18.420.010, will supersede certified peer counselors. On and after that date, only certified peer support specialists and peer support specialist trainees may provide Medicaid-reimbursable peer services.
    a. The number of billed Service Episodes provided by a CPC through this Contract are limited to no more than four (4) per month.
    b. The ECS Behavior Support Services provider must ensure that CPC is not the only professional providing services to the Client in any given month.

Consultation to the residential care provider billed through this Contract must be provided by the professionals described in the roles above.

Members of the Behavior Support Team shall be proficient in the following:

- Behavioral management strategies and planning for individuals whose abilities to remain in community settings are compromised by behavior and personal care needs;
- Development and implementation of formal and informal training on relevant topics for identified Clients and their residential care provider and/or staff; and
- Collaborative care planning, implementation, and documentation on behalf of identified Clients and their residential care provider and/or staff.

Contracted Behavior Support Provider Responsibilities

Behavior Support Team Responsibilities:

1. Respond to referrals from the HCS Regional Field Services Administrator or designated regional staff to provide Waiver ECS Behavior Support/Client Support Training services as authorized.
2. Upon receipt of a referral for an identified Client, arrange to have an initial visit with the Client using the following parameters:

a. If the Client has been referred while still in an institutional setting, meet with the Client and/or the Client's guardian and communicate with collateral contacts, at that setting within a timeframe established by HCS, for this referral to help support transition planning.
    - Services provided while the Client is in the institutional setting will be considered a part of the development of the required Behavior Support Plan and included in the episode(s) of billing associated with the delivery of the Behavior Support Plan or the initial outline of the plan as described in section 4.c., below.
    - In addition to the initial visit with the Client and/or the Client's guardian and collateral contacts, meet with the Client and/or the Client's guardian and the residential care provider in the residential setting, on the day the individual moves into his/her residence in the community, unless the HCS Field Services Administrator or designee has given explicit approval of an alternate schedule.
    - If there are extenuating circumstances, such as inclement weather or geographical barriers, that prohibit the Provider from meeting with the Client in an institutional setting face-to-face, the HCS Field Services Administrator or designee may authorize in writing that the initial visit may be conducted by phone or via telehealth. The Provider must document this authorization and the service(s) provided as well as the Client's consent to telehealth.

b. If the Client is referred while in a community setting, the initial visit with the Client must take place within three business days of the initial authorization, unless the HCS Field Services Administrator or designee has given explicit approval of an alternate schedule.
    a. If there are extenuating circumstances (such as inclement weather or geographical barriers) that prohibit the Provider from meeting with the Client in an institutional setting face-to-face, the HCS Field Services Administrator or designee may authorize in writing that the initial visit may be conducted by phone or via telemedicine. The Provider must document this authorization and the service(s) provided as well as the Client's consent to telehealth.

3. Provide a professional evaluation to assess individual's training and support needs related to behavior management and complete a Behavior Support Plan, using the following parameters:
    a. Develop the Behavior Support Plan based on information gathered from the Client and/or the Client's guardian, family members, residential care provider, HCS Regional Field Services Administrator or designee, and source of referral and/or any other sources identified as important by the Behavior Support Team. If the Client is in a hospital or other institutional setting, the Provider may provide no more than two (2) Service Episodes while the Client is in the hospital or other institutional setting. Services provided in a hospital or other institutional setting are considered complete and billable on or after the date the Client is enrolled in the waiver.

b. Identify a specific and measurable goal or set of goals that the Client will be working toward in terms of the Client's goals and safe interventions to address "identified behavioral problem(s)."
c. Inform HCLA/HCS of any barriers to implementing the Behavior Support Plan as soon as they are identified and provide details about the circumstances.
d. Design the Behavior Support Plan to prevent behavioral escalations or crises that lead to hospitalization and loss of community placement.
e. Outline strategies that the Client and the residential care provider can use to meet the goals and mitigate crises related to behaviors or other circumstances that put the Client at risk for loss of community placement.
f. Include the behavioral goals and timelines that address the behavioral and functional challenges identified in the individual's CARE assessment as well as problems or challenges identified by the Client and/or the Client's guardian and/or collateral contacts.

4. The Behavior Support and Crisis Plan (BSCP) must include the following elements:
   a. A crisis prevention and response protocol that outlines specific indicators which may signal a potential crisis for the Client;
   b. Identifies specific actions that staff or caregivers are to take prior to/during a crisis to assist the Client in maintaining community placement;
   c. Specific interventions and pre-crisis prevention strategies for each of the Client's indicators of a potential crisis;
   d. A crisis prevention and response protocol that outlines steps to be taken if the prevention or intervention strategies are unsuccessful in diverting the crisis, including the community crisis responder's coordination plan; and
   e. A description of how to respond to a Client's refusal of care or treatment, including when the Client's physician or practitioner should be notified of the refusal.
   f. In the event of any known hospitalization or need to assist during a crisis, provide the Designated Crisis Responder (DCR), Designated Mental Health Professional (DMHP) or other relevant crisis responders with pertinent information about the Client. Document the sharing of Client information for hospitalizations or crisis services and document the details of any known events leading to hospitalization or crisis services.
   g. If a Client is diverted from psychiatric hospitalization, prioritize the Client for a face-to-face visit the following business day.
   h. If a Client is treated at a hospital for any reason, upon re-admission to the residential facility, prioritize, based on Client need, a review of the medication list and the Behavior Support Plan to ensure any changes to either are addressed.
5. Clients who have an LRA issued by a court, the Provider should include this in the Behavior Support and Crisis Plan, including contact information for the Client's mental health team that has oversight of the LRA, and discuss the LRA with the residential care provider. It is expected that the ECS Provider and the LRA provider will communicate and coordinate to ensure consistent and clear expectations, responsibilities and roles.

6. Complete and revise the Behavior Support Plan and provide a copy of the completed Behavior Support Plan to the residential care provider, the Client and/or the Client's guardian, and the HCS field office within fourteen (14) business days of the initial visit with the Client.
7. Review and provide training on the details, goals and interventions of the Behavior Support Plan with the Client and/or the Client's guardian and the residential care provider and staff upon completion of the Behavior Support Plan with the Client in a residential setting.
8. If the Client was referred to this Contract while in a residential setting or was referred while in an institution and moves before the Behavior Support Plan is completed, supply the residential care provider an initial written outline of the Behavior Support Plan on the first visit with the Client at the residential setting.
    a. The purpose of the outline is to ensure that the provider and Client have strategies to support the stability of the placement and a clear protocol for communicating with Provider about behavioral challenges while the Behavior Support Plan is under development. The initial written outline must include:
    b. Behavior-specific support strategies the Client and provider can use to address the behaviors that initiated the referral for services, and
    c. Appropriate contact numbers the residential care provider should use if the Client's behaviors escalate.
9. Share, as needed, the crisis plan section of the Behavior Support Plan, with permission of the Client and/or the Client's guardian, with community partners including LRA, IRT or other providers who will support the Client.
10. Provide consultation and training to the residential care provider(s) that supports their ability to incorporate each Client's Behavior Support Plan into the Client's NSA or NCP.
11. Provide consultation and/or formal or informal training to caregiving staff in support of the implementation of the plan. All consultations and trainings to caregiving staff must be documented in the Client's clinical records. Documentation of the consultation and training must include dates and details, including topics discussed and any interventions identified.
12. Monitor the Behavior Support Plan monthly and update as needed to address emerging issues; and provide a formal review of the plan every six (6) months to ensure it reflects the Client's needs. The formal review will be conducted in collaboration with the residential care provider and HCLA/HCS, and copies will be forwarded to both. Provide any updates of Behavior Support Plan to the residential care provider.
13. Collaborate with primary health care team, the Client's current provider (residential or institutional), and/or other sources e.g., nurses, mental health technicians, substance abuse professionals, psychiatrists, dentists, crisis responders, hospital personnel, family, hospice providers or other community-based professionals, as appropriate, to help ensure progress toward Client care and Client goals identified in the Behavior Support Plan, who was involved in the development or modification of the Behavior Support Plan.
14. Make appropriate referrals to the BHO, BHSO, or MCO for ongoing assessment and treatment services, and collaborate with the BHO, BHSO, or MCO to coordinate services.
15. Provide a documented response capability that offers consultation and formal/informal training for the residential care provider and staff on a broad array of behavioral support topics that enable facility staff to circumvent crises for individual Clients.

a. The ECS program shall include the capacity to provide unscheduled onsite visits for management of behavioral challenges that compromise a Client's placement as outlined in the Behavior Support Plan.

16. Service Episodes can be provided at the rate specified in this Contract at any hour of the day or night, as necessary, to support an individual's ability to maintain community placement.
    a. The number of episodes provided to any particular Client per month will be discussed and coordinated with HCS staff who will provide final direction on the number of expected Service Episodes provided per week.
    b. The number of Service Episodes should reflect the Client's needs, with the expectation that more Service Episodes will be needed during the first several weeks or months of transition.
    c. Ensuing frequency of Service Episodes should reflect the Client's needs and be adjusted accordingly over time, as directed by HCS Field Services Administrator or designee. The Provider must provide and document at least one Service Episode per month.
    d. If, in order to achieve or maintain stability in a community placement, a Client requires Service Episodes during a specified period of time that would exceed the number of Service Episodes authorized by the region, the Provider must seek approval by the Regional Field Services Administrator or designee prior to providing additional Service Episodes.
    e. Unless the Client has access to psychopharmacological services through the behavioral health system, provide psychopharmacological evaluation for each Client within fourteen (14) days of the initial authorization of services and monthly reviews thereafter to ensure the individual medication regimen supports the Client's training goals.
        i. If the Client chooses to have psychopharmacological evaluation or reviews provided by another prescriber or is able to receive psychopharmacological evaluations through the behavioral health system, the Provider must document the name, address, and phone number of the prescriber in the Behavior Support Plan or Client record.
        ii. If the monthly medication review by the Provider's prescriber is a face-to-face or telehealth Service Episode, the Provider may bill for the Service Episode. Consent to telehealth must be documented in the Client record.
        iii. If the monthly medication review by the Provider's prescriber is a record review without the Client being present, the Provider may not bill for the Service Episode.
        iv. All psychopharmacological evaluations and monthly medication reviews must be documented in the Client record.
17. The Provider's prescriber must see the Client face-to-face or via telemedicine at least once every ninety (90) days, unless the Client has access to this service through the behavioral health system.
18. Under guidance and approval of HCS, establish processes for supporting Clients who may no longer benefit from the level of training and consultation provided by the services designated in this Contract.
    a. The intent of transition planning should be to evaluate, on a regular basis, each Client's progress toward reaching and maintaining the goals outlined in the Behavior Support Plan.

b. If a Client continues to need monthly clinical and prescriber services that are not otherwise accessed through the state's behavioral health system, maintain the Client on ECS or SBS services with written approval from the HCS Field Services Administrator or designee.

19. Inform DSHS/HCS of any changes that affect the Client's personal care plan or Behavior Support Plan on the next business day after the event; changes include, but are not limited to:
    a. Death
    b. significant change in medical or psychiatric condition
    c. calls to emergency or crisis responders, hospitalization, and
    d. encounters with law enforcement or other community agencies.

Case Manager's Responsibilities

In addition to the roles and responsibilities outlined in Chapter 3 of the LTC Manual: Assessment and Care Planning and as described in Chapter 5 of the LTC Manual: Case Management, the following are the responsibilities of the Case Manager:

1. Provide final approval for all Clients who are eligible to receive the services.
2. For each Client:
    a. Authorize Waiver Client Support Training/ECS Behavior Support through ProviderOne using the codes specified for each Client population;
    b. Track authorizations for each Client as necessary;
    c. Respond to Providers' requests for exception to rules related to limits on the number of Service Episodes within one week of request; and
    d. Provide a written explanation for denial of additional Service Episode requests.
3. Collaborate with the Providers to establish a plan of transition for each Client and work with Provider to review each Client's progress toward meeting the goals that would allow the Client to discharge safely from the program, if and when, those goals are met.
4. Meet with the Provider every six months or as needed to review Client progress or changes in condition.
5. Participate in monthly ECS provider update meetings (Either in-person or virtually) to review and update the Behavior Support Plan and NSA to support the Client's ability to maintain the community placement and minimize the use of emergency departments, hospitalizations, and crisis responders.
6. Coordinate monthly check-in meeting (Either virtually, telephonic, or in-person) with residential provider to ensure ECS services are supportive.
7. Conduct regular in-person records reviews to ensure Providers meets performance expectations.

Client Participation with behavior support services

If an ECS-eligible Client is unable or unwilling to participate in the development and implementation of their behavior support services, with the Client's consent, the Behavior Support Provider may continue providing training, support and consultation to the residential provider. Additionally, the Behavior Support Provider will continue to collaborate with the assigned prescriber to verify that medication management is being utilized by the Client.

The reason for the Client's lack of participation must be documented in CARE in a SER and addressed within the Comments section in the Behavior Screen as a future concern for a upcoming annual or significant change assessment.

Willingness and ability to participate should be revisited every 6 months along with the effectiveness and suitability of the service authorization.

Specialized Behavior Supports (SBS)

SBS is offered in:

- Adult Family Homes with an SBS contract

In collaboration with:

- An ECS-contracted Community Behavior Support Provider

SBS is offered in an AFH setting, when an RSW-eligible Client does not qualify for 1:1 enhanced staffing through CBHS state plan services.

Clients receiving SBS are provided the same Behavior Support Services as ECS along with 6-8 hours of daily 1:1, enhanced staffing provided by the residential staff to provide proactive supports identified in the Behavior Support Plan to engage in daily scheduled activities relevant to the interests, choices, abilities and goals of the individual.

What services are available under SBS?

- Personal care
- 24-hour on-site support and response staff
- The development and implementation of an individualized behavior support plan to prevent and respond to crises
- Medication management, and
- Specialized behavior support that provides six to eight hours a day of individualized staff time and planned activities.
    - **a.** Planned activities must be relevant to the residents' interests, choices, and abilities are planned and available daily. The activities program should include individual and some facilitated group activities. Opportunities for independent, self-directed and individualized activities should be available at any time; and.
    - **b.** Planned activities must be documented by the SBS contracted AFH in a calendar fashion to reflect caregiver engagement and activities provided.

SBS Providers' Qualifications and Responsibilities

AFH Residential Provider Qualifications

- Be an official AFH licensee with the State of Washington for twelve (12) months or more.
- Have had no significant enforcement actions, as determined by a review of the enforcement history, during the twelve (12) months preceding

AFH Residential Provider Responsibilities

- Coordinate the delivery of Behavior Support Services with an appropriate Behavior Support Provider who has a contract with DSHS to provide ECS;
- Prepare for and facilitate Behavior Support Services that will be provided in the AFH and will include training provided to or on behalf of specific SBS Clients in order to support each SBS Client's ability to remain in the community.
- Identify a Behavior Support Team for each SBS Client. The SBS team will include, but not be limited to the ECS Behavior Support Provider, facility staff and other professional staff involved with the ongoing care of the Client.
- Coordinate SBS Team meetings at least once a month for each SBS Client.
    - The Residential provider shall ensure facility staff attend the meetings and participate in the development of the Behavior Support Plan for each SBS Client. The Behavior Support Plan shall be incorporated into the SBS Client's Service Plan and NCP or NSA.
- Coordinate opportunities for staff and SBS Clients to receive training that supports each ECS Client. Training provided shall range from broad behavioral care topics to specific consultation and training related to the needs of the ECS Client. The training may be provided in cooperation with the Behavior Support Provider
- Collaborate with the Behavior Support Provider to develop a written Behavior Support Plan to respond to identified ECS Client indicators of potential crisis.
    - The goal of the Behavior Support Plan shall be to develop the ability to prevent and respond to crises. The program strategy shall include specific courses of action to respond to the needs of the SBS Client.
        - It will also describe the mechanisms that will be used to document facility staff training for each Behavior Plan.
        - The Behavior Support Plan strategy shall be developed cooperatively with appropriate parties. If the Client's physical or behavioral status changes significantly, the Provider shall immediately notify the HCS Social Worker and the Behavior Support Provider.
        - The Behavior Support Plan will be incorporated into the Client's NCP or NSA.
- Collaborate with the Behavior Support Provider to monitor for 1:1 enhanced staffing and activities calendar effectiveness or recommendations for modifications.

SBS 1:1 Residential Staffing and Activities Calendar

The AFH must, with the Client, develop a 1:1 staffing and activities calendar and provide it promptly to the case manager and Behavior Support Provider, if/when identified. The staffing and activities calendar must be included in the Client's Negotiated Care Plan. The Case Manager will upload documents to DMS.

1:1 Staffing

For every SBS resident served in the SBS contracted AFH, provide a minimum of 6 (six) hours per day of staffing in addition to the current staffing model in the AFH.
The current staffing model must include 24-hour staff presence for residents who are not SBS Clients.

The staffing schedule must contain all the following elements. An example has been provide for the AFH provider's convenience:

SBS Staffing Schedule Example

Name of Facility: _____ Date: _____

Name of Client: _____

Please identify the additional caregiver(s) that will be scheduled to meet the staffing requirement of 6-8 hours per day to provide 1:1 services and supports.
(For example: 1pm-3pm and 5pm-9pm or 6am-2pm)

Day of Week	**1:1 Caregiver Name**	**1:1 Time(s)**	**Name of Back-up 1:1 Caregiver** *(if 1:1 Caregiver is unavailable)*	**Routine Caregiver on Shift** *During 1:1 Shift(s)*
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

SBS Activity Plan Requirement Reminder

The SBS Contract requires the AFH Provider to have a written activity plan for each SBS resident. The activity plan must reflect activities that:

- support the SBS resident's strengths and needs and provide recreational opportunities specifically designed to meet behavioral challenges of the resident;
- can be integrated into the daily routine of the resident and staff; and
- address specific issues identified by the resident and the SBS Team.

The written activity plan must be incorporated into the SBS Client's Negotiated Care Plan.

The need for 1:1 enhanced staffing and individualized activities must be included in the Client's CARE assessment. The assigned Case Manager will provide the Client and AFH provider and the Behavior Support Provider with a copy of the Client's CARE Assessment.

Activities Calendar
With the Client and in coordination with the contracted behavior support provider, the Residential Provider will develop a written activity calendar to support each SBS resident's strengths and needs and provide recreational opportunities specifically designed to meet behavioral challenges of the resident.

Activities in this plan must be integrated into the daily routine of the resident and staff and must address specific issues identified by the resident and the SBS team.

The Case Manager will review the staffing and activities calendar and will write a Service Episode Record (SER) documenting the receipt and review of the calendar.

Note: it is expected that the 1:1 staffing schedule and activities change over time as the AFH, Behavior Support Provider and Client build rapport, trust and discover how to effectively design supports and interventions relevant to the individual's goals, preferences, needs.

Client Participation with Behavior Support Services

If a SBS-eligible Client is unable or unwilling to participate in the development and implementation of their behavior support services, with the Client's consent, the Behavior Support Provider may continue providing training, support and consultation to the residential provider. Additionally, the Behavior Support Provider will continue to collaborate with the assigned prescriber to verify that medication management is being utilized by the Client.

The reason for the Client's lack of participation must be documented in CARE in a SER and addressed within the Comments section in the Behavior Screen as a future concern for a upcoming annual or significant change assessment.

Willingness and ability to participate should be revisited every 6 months along with the effectiveness and suitability of the service authorization.

Community Stability Supports (CSS)

CSS is an RSW service that may be accessed and is only available in a licensed Assisted Living Facility or EARC with a CSS contract. This service is appropriate for Clients who, due to their behavioral and personal care needs, require a higher level of support than is available through ECS or SBS. Unlike ECS and SBS where behavior support services are provided by contracted ECS providers, CSS , behavior support services are provided onsite and are the responsibility of the CSS-contracted residential provider (ALF/EARC).

What services are available under CSS?

- Personal care
- 24-hour on-site support and response staff
- Medication management
- Onsite intermittent nursing services including nutritional services
- The development and implementation of an individualized behavior support plan to prevent and respond to crises
- Activity Program
- On-site staffing ratios and professional staffing as described in the CSS contract:

Staffing and CSS Provider Responsibilities

All CSS Clients receive enhanced services through an interdisciplinary team including but not limited to nursing, a Behavior Support Clinician, an Activities Coordinator, and caregiving staff.

There must be at least three (3) interdisciplinary staff on duty for each shift, and the minimum staffing requirements shall be provided with the following exception during the overnight shift:

- Nursing:
    a. RN/LPN staff on-site forty (40) hours per week and on-call providing twenty-four (24) hour coverage, seven (7) days per week. Nursing staff credentials must meet the medical complexity of the Client per WAC 246-840-700.
    b. Ensures access to Nutritional Services monthly to monitor weight and develop dietary plans (failure to thrive, eating disorder, morbid obesity, etc.).
    c. Ensures access to a Physician, Advanced Registered Nurse Practitioner, or Physician's Assistant for monthly medication review for all CSS Clients.
- Behavior Support Clinician:
    a. Available on-site forty (40) hours per week, to provide staff consultation, training, and professional level behavior support services to CSS Clients.
- Activity Coordinator:
    a. Available onsite forty (40) hours per week. Activity Program includes the following activities:
    b. Develop and maintain a structured meaningful activities program under the guidance and oversight of an Activities
    c. Will provide person-centered appropriate activities:
    d. Structured activities provided seven days per week and documented on a monthly activity calendar;
    e. CSS Clients must have an individualized, person-centered activity plan developed monthly, placed in their record and incorporated into their BSP.
    f. Scheduled and unscheduled facility and community-based activities for CSS Clients offering group and individual options.
- CNA/HC Caregiving Staff
    a. Staff designated to CSS Client care 24/7, with a minimum staffing ratio of 1:6 during the day and evening shifts.
    b. CNA/HCA staff are required to meet all Client needs to maintain the health and safety of all Clients.

Onsite Behavior Support Services

The Behavior Support Clinician will coordinate behavior support services for each CSS Client and will:

1. Conduct an initial evaluation of the Client's behaviors and behavior support needs to begin the process of developing the Behavior Support Plan (BSP), including identifying approaches and strategies for staff to manage the Client's behaviors during the transition to a new setting.
    a. Incorporate relevant behavioral and medical information from collateral contacts and admissions documents.
    b. Document and describe the behaviors and strategies in the Client's record within the first seven (7) days of admission.
2. Develop Behavior Support Plans (BSP), including an activity section, and Crisis Plans.
    a. The BSP must be written for each CSS Client within the first fourteen (14) days of admission and updated every six (6) months or more often as needed.
    b. The Behavior Support Clinician shall review the BSP with the Client and staff, as a person-centered guide to provide behavior support interventions and strategies, as well as for consultation and training needs.
    c. Within thirty (30) days, the BSP must be sent to the HCS case manager, reviewed with the facility staff, and incorporated into the Client's Negotiated Service Agreement (NSA).
    d. The Crisis Plan must identify a 24/7 response strategy that identifies someone from the interdisciplinary behavior support team to manage crisis response.
    e. Facilitate and document monthly, or more often as needed, interdisciplinary team meetings to review each Client's BSP, including medications and strategies, to ensure Clients' behavioral and medical needs are being addressed across the various disciplines; (i.e. may include Nurse, Prescriber, Social Worker, Activities Coordinator, Dietician, and HCS Case Manager).
3. Formally review and update the Client's BSP every six (6) months, or more often as needed, and provide copies to the HCS Case Manager.

Client Participation with Services

If a CSS-eligible Client is unable or unwilling to participate in the development and implementation of their behavior support services, with the Client's consent, the Behavior Support Provider may continue providing training, support and consultation to the residential provider. Additionally, the Behavior Support Provider will continue to collaborate with the assigned prescriber to verify that medication management is being utilized by the Client.

The reason for the Client's lack of participation must be documented in CARE in a SER and addressed within the Comments section in the Behavior Screen as a future concern for an upcoming annual or significant change assessment.

Willingness and ability to participated should be revisited every 6 months along with the effectiveness and suitability of the service authorization.

Enhanced Services Facility (ESF)

ESF provides the most intensive RSW services available and is only provided in an ESF-contracted setting. Unlike other services in the RSW, Enhanced Services Facilities have specific and required admission criteria required by WAC 388-107-0030. Also unlike other RSW services, an Enhanced Services Facility serves only RSW Clients as it is an exclusively-RSW setting serving individual who meet RSW criteria AND need staffing and services available only in an ESF.

Note: how teams and services are described is different than for other RSW services.

What services are available under ESF?

- Personal care;
- 24-hour on-site support and response staff per WAC 388-107-0240;
- The development and implementation of an individualized behavior support plan to prevent and respond to crises;
- Medication management; and
- On-site staffing ratios and professional staffing required in the ESF contract and WAC 388-107.

Staffing and ESF Provider Responsibilities

Staffing
When Clients are in the Facility, the ESF Provider shall ensure that at least two (2) staff are on duty and shall provide a staffing ratio of one (1) staff to four (4) Clients at all times.

If a Facility consists of more than one building under the same license, there must be at least two (2) staff on duty in each building and a staffing ratio of one (1) staff to four (4) Clients in each building at all times.

If, in order to meet the Clients' needs or medical complexity, a higher staff to Client ratio is necessary, then the ESF Provider shall provide additional staffing for all shifts.

The ESF must ensure the staffing ratios are met with the following credentialed staff, who are in good professional standing:

- Registered nurse;
- Licensed practical nurse;
- Nursing assistant certified or certified home care aide; and
- Mental health professional

The Enhanced Services Facility must ensure that:

- Sufficient numbers of appropriately qualified and trained staff are available to safely provide necessary care and services consistent with residents' person-centered service plans under routine conditions, as well as during fire, emergency, and disaster situations; and

- At least two staff are awake and on duty in the facility at all times if there are any residents in the facility.

1. A registered nurse must be available to meet the needs of the residents as follows:
    a. On duty in the facility at least twenty hours per week; and
    b. When not present, available on-call and able to respond within thirty minutes by phone or in person.
2. A licensed nurse must be on duty in the facility whenever a registered nurse is not on site.
3. A mental health professional must be available to meet the needs of the residents as follows:
    a. On duty in the facility at least eight hours per day; and
    b. When not present, available on-call and able to respond within thirty minutes by phone or in person.

ESF Provider Responsibilities

The ESF Provider shall provide as identified in the Client's Person Center Support Plan (PCSP) per WAC 388-107-0160:

a. Address complex behavioral needs, supervision, and coordination of services related to behavioral concerns, and supports for participants with traumatic brain injuries, substance use, or cognitive impairments;
b. Personal care services as specified on the Client's authorized PCSP based on the Client's CARE assessment; and
c. Health-related services including skilled or nursing care and medication administration to the extent permitted by State law.
d. Meet with potential Clients, referent staff, DSHS staff, and other involved parties as needed prior to admitting a DSHS Client to the Provider's facility.
e. Lead the pre-transition and coordination planning process.
    i. The ESF Provider must meet, either in-person or virtually with the prospective Client, the referent, and any relevant staff while the Client is hospitalized. The Contractor must complete a preadmission assessment, to include all of the elements per WAC 388-107-0040. The enhanced services facility will integrate information from the state's last comprehensive assessment reporting evaluation (CARE) into the facility's preadmission assessment.
f. Provide a homelike environment.
g. Develop a Person Centered Service Plan with each DSHS Client that lists all services to be provided and any other known service that is available to, or may impact, the Client. The PCSP must:
    i. Be based on the Provider Assessment or Reassessment completed by the Provider and the Client's CARE Assessment.

ii. Be developed in accordance with the format provided by DSHS and must include the following:

1. An Activity Section written to support each ESF Client's interests, strengths, and needs and provide for recreational opportunities specifically designed to meet the behavioral challenges of the Client. Activities must be integrated into the daily routine of the Client and staff and must address specific issues identified by the Client and the PCSP Team.
2. A Behavior Support Plan developed by the Facility's MHP that is designed to prevent crises and to maintain the Client's residency at the ESF. The Behavior Support Plan shall include the following elements:
    a. A Crisis Prevention and Response Protocol that outlines specific indicators, which may signal a potential crisis for the Client or that, when left unaddressed in the past, has led to a behavioral crisis.
    b. These signals would include, but not be limited to, typical behaviors the Client displays when escalating, actions the Client may typically take prior to a behavioral outburst, or words or phrases the Client has been known to express during a time of escalation.
    c. The Crisis Prevention and Response Protocol shall include a plan to ensure coordination with community crisis responders in regard to each Client's PCSP as part of a regular, routine protocol for crisis prevention and intervention. The Crisis Prevention and Response Protocol must include:
        i. Specific interventions and pre-crisis prevention strategies for each of the indicators described above;
        ii. A description of the types of holding techniques (if used by the Provider) that are safe for the Client; and
        iii. A Crisis Prevention and Response Protocol that outline steps to be taken by facility staff and by each of the PCSP Team members if the prevention or intervention strategies are unsuccessful in diverting the Client from a behavior or action that leads to crisis.
3. The Behavior Support Plan must include measurable goals, outcomes, and appropriate information needed to support the Client if he or she is ready to move from the ESF in order to live more independently in the community.
4. Maximize the opportunities for independence, employment, community participation and integration, the Client's participation in service planning, collaboration with peer-supported services, and the provision of care and services in the least restrictive manner appropriate to the individual Client, and, where relevant, to comply with any current court orders.

5. Be made available for review by the DSHS Case Manager and provided to the Case Manager on a yearly basis and as significant changes and updates are made.
6. Stipulations about Transitions to Other Community Settings.
    a. During the annual reassessment and/or significant change assessment the DSHS Case Manager and in collaboration with the PCSP Team shall discuss all available setting options and develop a plan of transition for ESF Clients who would like to move to another community setting, as required in WAC 388-107-0110 and 388-107-0120.
7. Document the specific procedure for de-escalating, preventing, and redirecting challenging behavior, to include: data collection, review and evaluation of interventions, behaviors and progress towards goals/outcomes.
8. The specific assessed need is identified in the PCSP, which is signed by the Client;
9. Participation by the Client in the development of the PCSP;
10. Other positive interventions and less restrictive interventions that have **not** been successful;
11. Any impacts to other Clients and how those will be addressed;
12. Staff training on prevention of escalation of behavior, consistent with the requirements below.
13. Techniques for staff to use in response to challenging behaviors; and
14. If the facility uses holding techniques as a last resort to physically restrain residents in emergency situations and as part of behavioral intervention protocols, provide an Incident Report on the reason, the interventions used, the duration, and the Client's condition when the hold is released.
15. Plan and make available the activities relevant to the Clients' interests, choices, and abilities. The activities program must include:
    a. Daily facilitated group activities, that provide opportunities for Clients to choose whether or not to participate;
    b. Opportunities for independent, self-directed and individualized activities that are available at any time; and
    c. Activities in the local community.
        i. Advance notice must be given to Clients for activities that require the Client to pay for participation (such as entrance fees to parks/events, bowling, movies, dining out)

16. Provide behavior support services as identified in each Client's PCSP;
17. Coordinate with the entity that administers Medicaid-funded behavioral health services int he local community; and.
18. Ensure that Quality Improvement measures are in place as outlined in the contract.

PCSP Team Roles

The ESF Provider must:

1. Develop and maintain a PCSP Team for each Client. The Team must include:
    a. The Client and, the Client's representative (if applicable);
    b. Individuals chosen by the Client;
    c. A mental health professional;
    d. Nursing staff;
    e. The Client's DSHS Case Manager; and
    f. Other persons as needed.
    g. Additional Team members may be added to the PCSP Team:
    h. If requested by the Client or the Client's representative; or
        i. To address specific needs identified by the Client or any other member of the Team on either a one-time or ongoing basis.
    i. Provide the necessary information and support to ensure that the Client has an opportunity to identify Team members, make informed choices and decisions regarding care and services, and direct the PCSP process to the maximum extent possible.
    j. Ensure a coordinated approach to the development, implementation and evaluation of the comprehensive PCSP for the Client.
    k. Ensure the PCSP Team meets at least monthly and more often as needed, at times and locations convenient to the Client, to review and modify the comprehensive PCSP when necessary.
    l. Convene additional PCSP Team meetings as needed if the Client is experiencing signs or symptoms of crisis that:
        i. Put a Client at risk of hospitalization, institutionalization, or loss of residence; and/or
        ii. Exceeds a Client's individual ability to cope/remain stable; and/or
        iii. Exceeds the ability of the Client's caregivers to provide the necessary supports.

m. Ensure the Facility staff attend the meetings and participate in the development and review of the PCSP for each ESF Client. All work performed under this Contract and any PCSP shall be performed under WAC 388-107-0190 Rights of Resident.

n. Confirm the PCSP Team develops one PCSP for each ESF Client.

o. Verify the development of the PCSP included collaboration with the Client and the Client's self-identified support team.

p. Confirm the PCSP Team reviewed and updated the PCSP monthly and after each Contractor Assessment and Reassessment, as needed.

q. Document in writing all PCSP Team meetings to reflect who was present, the topics discussed, any decisions made, and activities the Client participated in since the last PCSP Team meeting.

Client Participation with Services

If an ESF-eligible Client is unable or unwilling to participate in the development and implementation of their behavior support services, with the Client's consent, the Behavior Support Provider may continue providing training, support and consultation to the residential provider.

The reason for the Client's lack of participation must be documented in CARE in a SER and addressed within the Comments section in the Behavior Screen as a future concern for an upcoming annual or significant change assessment.

Willingness and ability to participated should be revisited every 6 months along with the effectiveness and suitability of the service authorization.

Enhanced Services Facility Utilization and Admission Criteria

In addition to meeting the RSW eligibility criteria as determined in CARE, per WAC 388-107-0030, ESF has additional Client criteria that must be met prior to admission.

A Client MUST:

- Eighteen years old or older
- Require daily care by or under the supervision of a mental health professional, chemical dependency professional, or nurse; **OR**
    a. Assistance with three or more activities of daily living; **and**
- Have any of the following:
    a. A mental disorder, chemical dependency disorder, or both;
    b. An organic or traumatic brain injury; or
    c. A cognitive impairment that results in symptoms or behaviors requiring supervision and facility services.
- Benefit from the enhanced staffing levels and professional supports provided in this setting;

- If at the state hospital, community hospital, or psychiatric hospital/stabilizing facility, has been deemed stable and ready for discharge. **AND**
- Does not meet the requirement for active treatment at a state hospital, but has not found a community setting sufficient to provide the services and supports to successfully live in the community due to a history of **two or more** of the following:
    - **a.** Aggressive, threatening, or assaultive behaviors that create a risk to the health or safety of other residents or staff, or a significant risk to property and these behaviors are frequent or difficult to manage; **AND/OR**
    - b. Intrusive behaviors that put residents or staff at risk; **AND/OR**
    - **c.** Complex medication needs which include psychotropic medications; **AND/OR**
    - d. A history of or likelihood of unsuccessful supports in either a licensed facility or other state facility **or** a history of rejected applications for admission to other licensed facilities based on the resident's behaviors, history, or security needs; AND/**OR**
        - A history of offenses against a person or felony offenses that created substantial damage to property, **and/or**
        - A history of frequent or lengthy mental health hospitalizations

ESF Provider Responsibilities

Immediately upon a Client requesting admission to the ESF, the CM must provide the Client's CARE assessment.

Upon admission of a Client to the Provider's ESF, the Provider shall prepare a Client file,

The Provider must notify the DSHS Case Manager in writing when a Client requires more care than the Provider can provide**.**

In addition, the Provider must notify the DSHS Case Manager when the Client's care needs change and do not return to the level of care of the current assessment within a two-week period of time.

The enhanced services facility must complete a face-to-face or virtual preadmission assessment at the hospital with each potential resident prior to admission which includes the following minimum information:

1. Resident identification information such as but not limited to the name, address and telephone number of the resident's:
    - i. Representative;
    - ii. Health care providers;
    - iii. Significant family members identified by the resident;
    - iv. Other individuals the resident wants involved or notified; and
2. Presenting issues;
3. Current medical and mental health history;

4. Necessary and contraindicated medications, including psychotropic;
5. A licensed medical or health professional's physical and mental health diagnoses;
6. Significant known behaviors such as but not limited to aggressive, threatening, intrusive, assaultive, self-endangering including attempted suicide and/or homicide or other symptoms that may cause concern or require special care and staffing;
7. Chemical dependency history, including tobacco;
8. Level of personal care needs, assistance with activities of daily living;
9. Activities and service preferences;
10. Preferences regarding other issues important to the prospective resident, such as food and daily routine;
11. Information that a potential resident is or is not court-ordered for treatment or under the supervision of the department of corrections;
12. Individual's anticipated level of need for supervision in the community;
13. Cognitive impairments that result in symptoms of behaviors requiring supervision and facility services;
14. History of unsuccessful placement in the community settings; and
15. Treatment recommendations or recommendations for additional program-specific assessment.
16. A transition plan that:
    i. Allows the facility to work with the referent staff to understand what the resident responds to in difficult situations; and
    ii. Allows the facility to request referent staff to visit resident in new environment and teach enhanced services facility staff techniques that have been successful in the hospital.

GUIDANCE FOR 1:1/ENHANCED STAFFING IN RESIDENTIAL SETTINGS

Referrals to CBHS/1915i and RSW should be initiated concurrently for Clients who meet criteria for both programs and are interested in 1:1/enhanced staffing, allowing RSW services to provide additional wraparound supports.

To support this transition, Washington Administrative Code (WAC) sections 388-106-0336 and 388-106-0338 were amended, effective July 1, 2025. These amendments clarify CBHS/1915i State Plan is the first program of consideration and authorization for 1:1/enhanced staffing in a residential setting. If a Client meets eligibility for CBHS, this service must be referred to, prior to RSW services.

- **CBHS State Plan**: Administered by HCA under the 1915(i) authority, this program offers 1:1/enhanced staffing referred to as supportive supervision.

- **RSW program**: Managed by HCLA, this waiver provides enhanced staffing services through various levels of services.

For CBHS specific information and documentation please reference *Community Behavioral Health Support (CBHS) Services Residential* section in the Long-Term Care Manual for information regarding Behavioral Health Wraparound Supports (BHWS) Chapter 22a: Apple Health Managed Care and Apple Health Medicare Connect (D-SNP).

For RSW and CBHS staff resource please reference LTC Manual Chapter 22d: Community Behavioral Health Supports

RSW Services Offering 1:1/Enhanced Staffing

Specialized Behavior Support (SBS)

- Can only be authorized for Clients who do not meet CBHS eligibility.

Community Stability Supports (CSS)

- Prior to authorizing ESF services, a CBHS referral must be considered and sent if Client meets CBHS/1915i eligibility including having a qualifying diagnosis and meets other criteria as outlined in LTC Manual Chapter 22d: Community Behavioral Health Supports and consents to services.
- CSS rate is only available to Clients not eligible for CBHS.

Enhanced Services Facility (ESF)

- Prior to authorizing ESF services, a CBHS referral must be considered and sent if Client meets CBHS/1915i eligibility including has a qualifying diagnosis and meets other criteria as outlined in LTC Manual Chapter 22d: Community Behavioral Health Supports and consents to services.
- Full ESF rate is only available to Clients not eligible for CBHS.

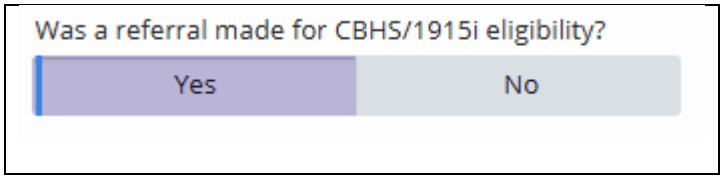
Process for accessing Community Behavioral Health (CBHS) state plan for 1:1 enhanced staffing and RSW Services within the CARE assessment.

Is the Client interested in 1:1/enhanced staffing in a residential setting?

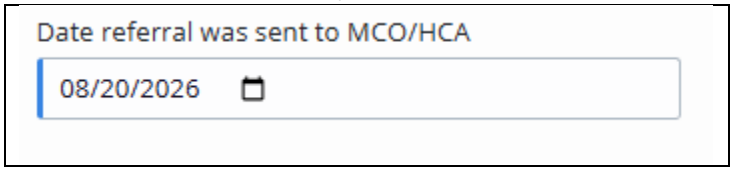
- **Yes** → Document a SER in CARE Client's agreement with CBHS referral.
- **No** → Document a SER in CARE Client declining need for 1:1 enhanced staffing

Does the Client meet CBHS/1915i referral criteria? (Community Behavioral Health Support Services)

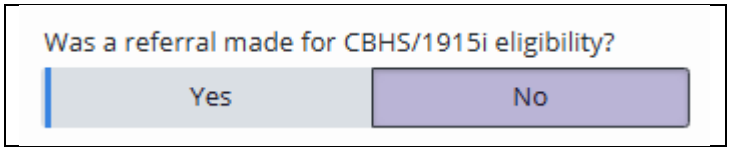
- **Yes** → Answer "Yes" for CBHS referral question "*Was a referral made for CBHS/1915i eligibility?*" within the Behavior screen of the CARE assessment.



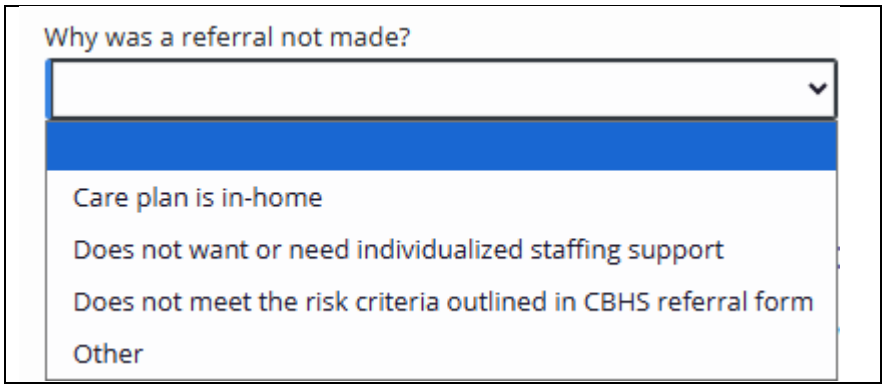
- → Enter date referral was sent to MCO/HCA.



- **No** → Answer "No" for CBHS referral in Behavior screen of CARE assessment.



→ **Utilize drop-down answers within the Behavior screen for CBHS referral and reason for declining 1:1 /Enhanced staffing**

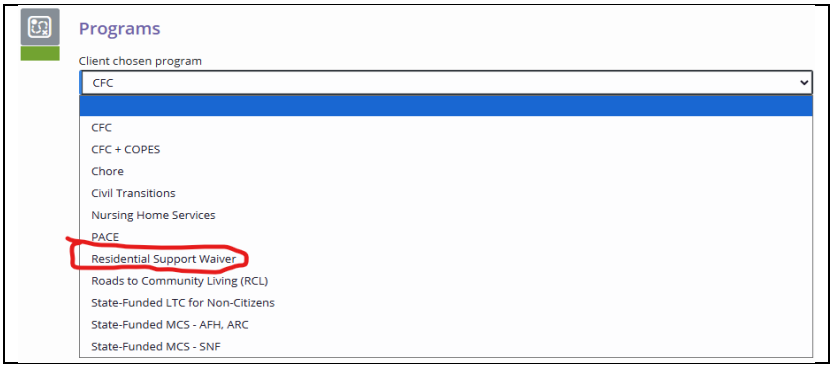


  - Select "other" for the reason no referral was made. Document the reason the CBHS referral was not made in the required comment box.

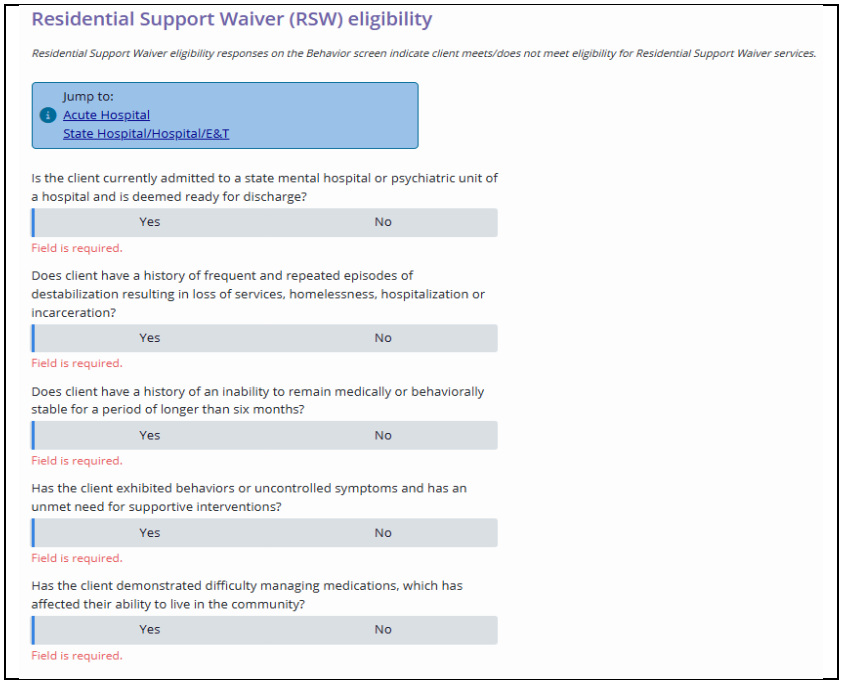
What if my Client declines a CBHS referral?
Declining a referral for 1:1 / enhanced staffing through CBHS means they are also declining a referral for 1:1/enhanced staffing through RSW (SBS, CSS and ESF).

Does the Client meet RSW criteria per CARE?

- **Yes** → RSW will populate in the Care Plan screen for Client Chosen Program



→Proceed with Referral to RSW Committee (See section below);
→ Answer RSW Eligibility questions within the Behavior screen of the CARE assessment



- **No** → Continue eligibility determination for other programs

See LTC Manual Chapter 22a – Apple Health Managed Care and Medicare Dual-Eligible Special Needs Plans (D-SNP) to review criteria for **Community Behavioral Health Support (CBHS)** services paid by a Managed Care Organization (MCO) or Health Care Authority (HCA). Chapter 22a includes the process for requesting funding from the MCO/HCA if additional supports are needed. CBHS services is a State Plan service and must be utilized prior to authorizing RSW services if the Client is eligible.

NOTE: Expanded Community Services (ECS) does not offer 1:1/enhanced staffing. **CBHS referral is not required**.

CARE Assessment and RSW Referral

- The HCS/AAA Case Manager completes a CARE assessment, in accordance with Chapter 3 and Chapter 8 of the LTC Manual
- RSW Eligibility Questions answered—RSW Eligibility determined in CARE
- The HCS/AAA Case Manager submits the RSW referral to the RSW Committee using the RSW Referral Submission Process for HCS/AAA Case Managers. Note: each region's process is slightly different. Please follow your region's process.

RSW Referral Submission Process for HCS/AAA Case Managers

HCS Case Managers submit RSW referrals to:

Region 1: hcsrsw@dshs.wa.gov
Region 2: http://region4aasa.dshs.wa.gov/RSW/Main.asp
Region 3: R3 RSW Referral request

AAA Case Manager emails RSW referrals (DSHS form 11-130) to:

Region 1: hcsrsw@dshs.wa.gov
Region 2: r2rsw@dshs.wa.gov
Region 3: aaarswreferrals@dshs.wa.gov

Regional RSW Committees and Case Manager Responsibilities

- The RSW Committee reviews the referral and confirms functional, financial eligibility and that a CBHS referral was made when appropriate.
- If the Client *does not meet eligibility*, the committee documents the outcome on DSHS form 11-130, provides a SER that cites which criteria were not met, and communicates the decision to the Case Manager via email.
- If Client's eligibility and CBHS referral appropriateness is confirmed, the Case Manager coordinates discussion and coordination with the Client to identify how their assessed needs will be best met among the RSW services and settings.
- The Case Manager will complete DSHS form 11-130 to indicate the Client's choice of services.
- The completed DSHS form 11-130 is submitted to DMS by the Case Manager.

HOW TO SUBMIT REFERRALS TO A RESIDENTIAL PROVIDER?

Referrals

Referrals must include Assessment Details (AD) and Service Summary (SS) to allow the provider to review prior to admission. Additionally, for individuals with challenging behaviors (i.e., assaultive, property destruction, self-injurious, challenging sexualized behaviors, history of arson, and/or history or criminal activity), the assigned case manager or assessor must complete DSHS 10-234a and include in the residential provider referral packet per Chapter 9a of the LTC Manual.

Note: See Admission Criteria for ESF WAC 388-107-0030

Behavior Support Services CARE Requirements

Clients authorized for RSW services must have at least one of the following identified in CARE under the Medical Treatment section for all residential settings (AFH, ALF, and ESF):

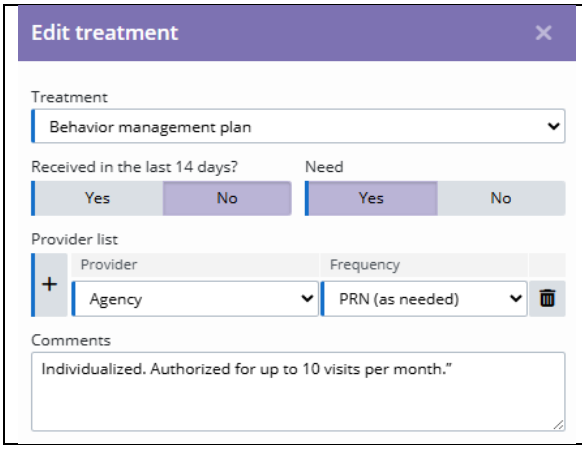
- Behavior Management Plan (BMP)
- Behavior Evaluation Program (BEP)

Implementation Guidelines

Utilization of BMP or BEP is dependent on the Client's specific needs and setting, utilization of state plan and MCO services. CSS and ESF providers are required to complete a BEP prior to admission and have a functional BMP for ongoing supports. AFH providers are required to coordinate with Behavior Support Providers (BSP) for the completion of a BMP for the entirety of a Client's admission.

Examples of the use of BMP & BEP within CARE

BMP for ECS, SBS Client:

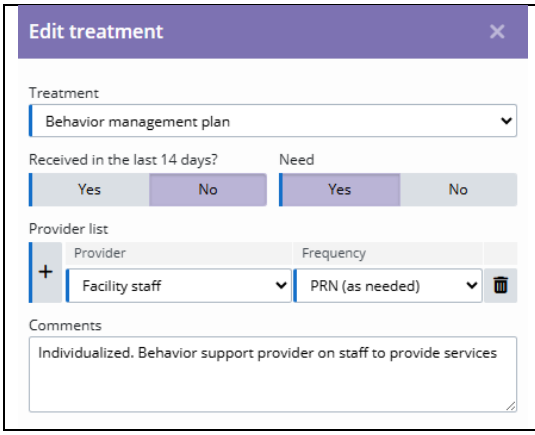


Provider: "Agency" (there is no separate option for "Behavior Support Provider" as BSPs for ECS/SBS Clients are contracted, so "Agency" is the best option).

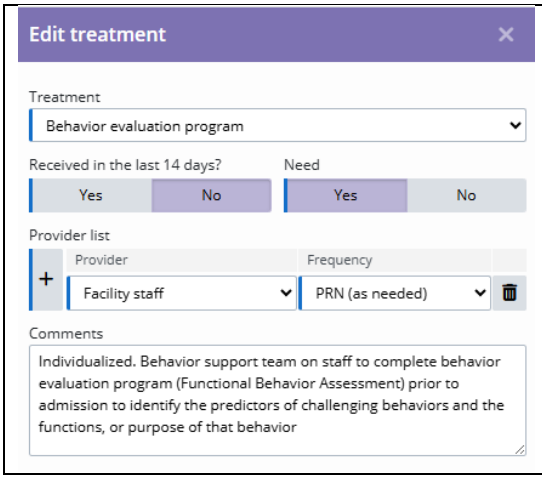
Frequency: "PRN (as needed)" (Entering PRN indicates that the frequency is individualized and could change over time.)

Comments: "Individualized. Authorized for up to 10 visits per month."

BMP for CSS or ESF Client:

	**Provider:** "Facility staff" (CSS/ESF facilities are required to have a behavior support provider on staff) **Frequency:** "PRN (as needed)" (Entering PRN indicates that the frequency is individualized and could change over time.) **Comments:** "Individualized. Behavior support provider on staff to provide services."

BEP for CSS or ESF Client:

	**Provider:** "Facility staff" (CSS/ESF facilities are required to complete a Behavior Evaluation Plan prior to admission based on the needs of each Client) **Frequency:** "PRN (as needed)" (entering PRN indicates that this program is individualized). **Comments:** "Individualized. Behavior support team on staff to complete behavior evaluation program (Functional Behavior Assessment) prior to admission to identify the predictors of challenging behaviors and the functions, or purpose of that behavior".

CASE MANAGER RESOURCE FOR PROVIDERS

FACILITY LOCATOR

- AFH Facility Search (wa.gov)
- Assisted Living Facility Locator
- ESF Locator

AUTHORIZING RSW SERVICES

Authorization for RSW Medicaid coverage (ECS, SBS, CSS, ESF) is a two-step process for initiating Recipient Aid Categories (RACs) and services. Case Managers may open RSW RACs for Clients who have pre-existing HCS services (CFC, CFC+COPES, etc.) on the day of RSW eligibility approval by the RSW

Committee.* This will allow for any needed pre-transitional Behavior Support services prior to the Client's admission to ECS or SBS contracted AFHs.

In the case where a Client has no pre-existing services, the authorization period for RSW Services begins on the first day the Client arrives at the community residential setting that is contracted to provide the service.

For ECS and SBS services, the Behavioral Support Provider (BSP) must also be confirmed by the Case Manager to authorize services. Authorization of BSP services is dependent on confirmation by the BSP to provide services, if any pre-transitional BSP support planning is needed or requested by the referent or AFH provider, and the start date the BSP provider commits to. In some situations, contracted Behavior Support Services may be authorized for a limited number of episodes to facilitate pre-transition behavior support activities with the aim of supporting a successful transition.
Prior to service authorization for SBS services, an approved staffing calendar from the AFH is required.

Clients admitted to an ESF require coordinated transition planning to ensure all preparations have been completed and the Client and the Provider are ready for admission.

In cases where Clients are transitioning from existing services to RSW, start dates for RSW RACs and authorization of services require Case Manager coordination to determine effective end and start dates for RACs and authorization of services.

When communicating with Public Benefits Specialists (PBS) regarding RSW Clients, Case Managers will use the Financial/Social Services Communication Form (DSHS 14-443). On the form:

- Select the RSW program for all RSW Clients
- Select the CFC program if the RSW Client is also receiving an ongoing CFC Ancillary service. Do not select CFC if the RSW Client is getting a one-time CFC service.

For more information on how financial eligibility is determined, see Chapter 7a: Financial Eligibility of Core Programs of the LTC Manual.

RACs for RSW Services

Program Name	RAC Code
ESF	3030
AFH-SBS	3031
Expanded Community Services	3032
ESF Fast Track*	3033

Program Name	RAC Code
SBS Fast Track*	3034
ECS Fast Track*	3035
CSS Fast Track*	3038
CSS	3039
CFC Ancillary Services	3056
RSW CFC Ancillary Services Fast Track*	3057

*For more information on Fast Track, see Chapter 7a of the LTC Manual.

FAST TRACK

Fast Track may be considered for RSW if a Client does not have a disability determination and is open on MAGI-based NO5 program. A Non-Grant Medical Application (NGMA) must be completed to begin this process and should be done early in the assessment process. For more information on Fast Track, see LTC Manual Chapter 7h: Appendices.

Utilization of the RSW Fast Track RAC is dependent on Case Manager submission of NGMA application and approval from regional RSW Committee for RSW services and should only be done in rare cases if the NGMA has not yet been approved. By using the Fast Track RACs for these Clients, they will be able to receive RSW services as soon as they move into a community setting. However, best practice is to confirm NGMA approval prior to discharge to ensure waiver eligibility and service continuation.

Case Managers are required to monitor the NGMA determination of a Client. Once approval of NGMA is received and adjust RACs and authorizations to reflect financial approval for waiver services.

In rare cases, a Client may be found ineligible for waiver services because of NGMA denial, requiring adjustment of RACs to State Only Adjustment of Payment (SOAP) RACs. Utilization of RSW RACs will require supervisory oversight to override mismatch authorization errors. Person-centered planning will need to occur, to transition the Client to an eligible program such as Community First Choice (CFC) state plan option.

NOTE:	• RSW Fast Track eligibility is allowed for MAGI/NO5. Please reference Fast Track Service Agreement (DSHS form 13-713) process outlined in Chapter 7a in the LTC Manual.

	• RSW Fast Track eligibility is allowed for NGMA applications. Please reference Instructions for Completing NGMA Referral in Barcode outlined in Chapter 7h of the LTC Manual.

Authorizing Personal Care and RSW Add-On Rates

In the RSW, personal care services are bundled into the Client's daily rate. When selecting one of the RACs listed above, authorization includes these personal care services.

For ECS, SBS, CSS, and ESF personal care add-ons include both Clients eligible and not eligible for CBHS. Refer to the current *All_HCS_Rates.xls* or consult the Service Code Data Sheets for additional details.

Authorizing ECS

When a Client is approved for ECS and chooses a contracted residential provider, the Case Manager will authorize the following codes:

ECS in AFH	
1. Personal Care Service Code:	T1020_U1_Personal_Care_Residential_AFH
2. ECS Service Code:	T2033_U1_AFH_Add-On

Authorizing SBS

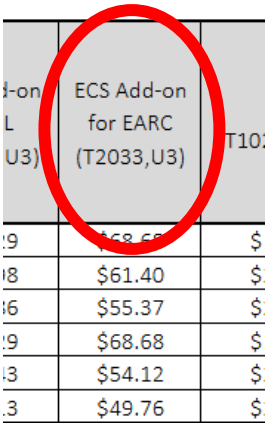
When a Client is approved for SBS and chooses a contracted AFH, the Case Manager will confirm that the SBS staffing Schedule is completed (Reference SBS Staffing Requirements) and will:

SBS in AFH	
1. Personal Care Service Code:	T1020_U1_Personal_Care_Residential_AFH
2. SBS Service Code:	T2033_U5_RSW_SBS_AFH_Add_on
NOTE: Case Managers must consult Home & Community Services Rates to enter correct CARE Classification rate for SBS Add-on for RSW SBS AFH Add-on (T2033 U3)	

ECS in ALF	
1. Personal Care Service Code:	T2031_Assisted_Living
2. ECS ALF Add-on Service Code:	T2033 UA
3. ECS EARC Add-on Service Code:	T2033_U3_EARC_Add_On
4. ECS ALF Service Code:	T2033 UA

ECS in EARC	
1. Personal Care Service Code:	T1020_U3_Personal_Care_Residential_ARC_Enhanced
2. ECS Service Code:	T2033_U3_EARC_Add_On

NOTE: Case Managers must consult Home & Community Services Rates to enter correct CARE Classification rate for ECS Add-on for EARC (T2033 U3)



-on L U3)	ECS Add-on for EARC (T2033,U3)	T10
9	[illegible]	$
8	$61.40	$
6	$55.37	$
9	$68.68	$
3	$54.12	$
.3	$49.76	$

Authorizations for ECS or SBS are approved to accommodate regional absence of Behavior Support Provider. There is no defined limitation on the duration of these authorizations and are dependent on Case Managers coordination for next available Behavior Support Provider.

ECS or SBS add-ons may be temporarily authorized for AFHs when:

- The Client has an assessed behavior support need
- The Client elects to receive ECS or SBS services
- A behavioral support provider is not currently available

In these cases, the HCS Case Manager will coordinate with the local RSW supervisor to review alterative plans to temporarily meet the Client's behavioral health needs until a qualified behavioral health provider is authorized to serve the Client. (Per Adult Family Home Council Collective Bargaining Agreement 2025-2027)

NOTE: A Behavior Support Provider should be in place prior to starting ECS/SBS services. If not, Case Managers should, with the Client, prospective provider and transition partners, document the plan and timeline for when a BSP will be in place. Some transition activities may impact the timing of establishing a BSP prior to start of ECS/SBS services.

Authorizing CSS Add-on Rates

When a Client is found eligible, agrees to CSS services, and chooses a CSS-contracted ALF the Case Manager will authorize the following:

1. Personal Care Service Code : T1020, U3 Personal Care Residential – EARC*
2. CSS Service Code: T2033 U4 CSS Add On*
   - If the Client is eligible for Community Behavioral Health Support (CBHS) Services (Reference for detailed CBHS information). Authorize the CSS Add On rate which does not include the 1:6 enhanced staffing.
   - If the Client does not meet eligibility criteria for CBHS, authorize the CSS Add On rate, which includes the 1:6 enhanced staffing ratio.

CSS	
1. Personal Care Service Code:	T1020_U3_Personal_Care_Residential_ARC_Enhanced
2. SBS Service Code:	T2033_U4_CSS_Add_on

NOTE: Case Managers must consult Home & Community Services Rates to enter the correct rate and reason code based on the Client's CBHS eligibility/ineligibility

For CSS Clients eligible for Community Behavioral Health Supports (CBHS):			
CBHS Tier	Service Code/ Modifier	**Reason Code**	**Rate**
Tier 1	T2033,U4	MCO Funded Tier 1	$115.00
Tier 2	T2033,U4	MCO Funded Tier 2	
Tier 3	T2033,U4	MCO Funded Tier 3	
Tier 4	T2033,U4	MCO Funded Tier 4	
Tier 5	T2033,U4	MCO Funded Tier 5	
Tier 6	T2033,U4	MCO Funded Tier 6	

For CSS Clients not eligible for CBHS:			
CBHS Tier	Service Code/ Modifier	**Reason Code**	Rate
n/a	T2033,U4	No Reason Code Needed	**$245.00**

Authorizing ESF Rates

When a Client is eligible, agrees to Enhanced Services Facility (ESF) support, and selects an ESF-contracted residential provider, the Case Manager will authorize the following:

1. Personal Care Service Code: T1020_U5_Personal_Care_RSW_ESF*
2. The authorized rate depends on the Client's funding source and CBHS tier approval.

- Clients **Not eligible for CBHS**
  - Service Code: T1020_U5_Personal_Care_RSW_ESF*
  - Reason Code: Not required

For Clients not eligible for CBHS in an ESF:			
Tier	Service Code/ Modifier	Reason Code	Rate
n/a	T1020,U5	No Reason Code Needed	$596.10

- Clients **Eligible for CBHS**
  - Clients approved for Community Behavioral Health Support (CBHS) services will be assigned one of six tiers. Each tier includes:
    - Service Code: T1020_U5_Personal_Care_RSW_ESF*
    - Reason Code: CBHS Funded Tier Level Client is approved for
      - A supplemental payment made directly by CBHS/HCA to the ESF provider (not entered in CARE)

For Clients eligible for Community Behavioral Health Supports (CBHS) in an ESF:			
Tier	Service Code/ Modifier	**Reason Code**	**Rate**
Tier 1	T1020,U5	MCO Funded Tier 1	$559.80
Tier 2	T1020,U5	MCO Funded Tier 2	$498.09
Tier 3	T1020,U5	MCO Funded Tier 3	$401.29
Tier 4	T1020,U5	MCO Funded Tier 4	$390.95
Tier 5	T1020,U5	MCO Funded Tier 5	$390.95
Tier 6	T1020,U5	MCO Funded Tier 6	$390.95

NOTE: ETRs will not be accepted for ESFs.

NOTE: Clients who agree to services at Unified Residential Care in Spokane are eligible for provider rate enhancement. The Case Manager will authorize the following:

For Clients at Unified Residential Care in Spokane eligible for CBHS:			
Tier	Service Code/ Modifier	Reason Code	Rate
Tier 1	T1020,U5	MCO Funded Tier 1	$583.80
Tier 2	T1020,U5	MCO Funded Tier 2	$522.09
Tier 3	T1020,U5	MCO Funded Tier 3	$425.29
Tier 4	T1020,U5	MCO Funded Tier 4	$414.95
Tier 5	T1020,U5	MCO Funded Tier 5	$414.95
Tier 6	T1020,U5	MCO Funded Tier 6	$414.95

For Clients at Unified Residential Care in Spokane not eligible for CBHS:			
Tier	Service Code/ Modifier	Reason Code	Rate
n/a	T1020,U5	No Reason Code Needed	$620.10

Authorizing Contracted Behavior Support Provider (BSP) for ECS or SBS Clients

The maximum number of episodes or units of Behavior Support is 10 per month. Any request by the BSP for episodes in excess of 10 per month will require supervisory approval. Each ECS/SBS Client must receive a minimum of 1 unit per month to remain qualified for ECS/SBS.

The contracted Behavior Support service for AFHs is not available for the CSS service or in an ESF as those settings provide behavior support as part of the service package provided in the facility.

When an ECS or SBS Client is approved for Behavior Support, the Case Manager will authorize the Behavior Support service using Service Code: T2025, U3 Client Training, Intensive Behavior Support.

Behavior Support services include:

- A professional evaluation to assess the Client's behavior support needs and a written Behavior Support Plan;
- A Crisis Plan to address steps for the residential setting staff to take when faced with a crisis situation, including a list of all formal and informal supports, medications, and strategies to use for de-escalation;

NOTE: The Behavior Support Plan and Crisis Plan may be referred to as BS/CP

- Regularly scheduled behavior support visits in the Client's residence, usually one to two times per week, with no more than ten visits per month (the HCS Field Services Administrator or designee may pre-approve additional visits on a case-by-case basis);
- Specialized training and consultation to facility staff on managing the Client's behaviors; and
- Monthly psychopharmacological management to ensure that appropriate levels and types of medications are prescribed.

An episode of service by a Behavior Support Provider must be at least a 15-minute interaction that is usually done in-person (but can be done by phone or virtually on a limited basis). If a staff of the Behavior Support Provider is dually credentialed (such as a Prescriber and a Clinician), the Behavior Support Provider may **not** bill for two separate services delivered by a dually credentialed staff on the same day.

Behavior Support Plans and Crisis Plans (BSCP) must be updated at least every six months. The Behavior Support Provider must provide a copy of all updated Behavior Support and crisis plans to both the residential setting provider and the Case Manager.

Note: The Behavior Support Provider may provide up to two episodes of service to individuals who are not in a residential setting, under the following specific criteria:

Criteria #1: The individual has not yet moved into a residential setting – The Behavior Support Provider could visit potential Client to develop a Behavior Support Plan and prepare the individual to transition into a community setting. These visits would occur in acute care hospitals or institutional settings (such as state hospitals, residential treatment facilities, or evaluation and treatment centers). The Case Manager must confirm the dates of the requested visits with the BSP and enter an authorization under RSW RAC that coincides with the Client's residential admission date. The BSP service is allowed to date and submit a claim for the visits after the authorization/admission date with supportive documentation that reflects visit(s) occurred prior to authorization. Utilization of SOAP RAC for BSP services is allowable for Clients discharges that fail to admit under RSW Services. *The Behavior Support provided must not include any duplicative services that would otherwise be available to the individual in the inpatient setting.*

If the individual has already moved into a residential setting and subsequently leaves the residential setting for a medical hospitalization in an acute care hospital or community hospital for a temporary stay, the Behavior Support Provider **may** visit the Client to provide services in alignment with the Behavior Support Plan.

Criteria #2: If the individual has already moved into a residential setting and subsequently leaves the residential setting for a mental health or behavioral hospitalization by going into an institutional setting (such as a state hospital, residential treatment facility, or evaluation and treatment center), the Behavior Support Provider **may not** provide services to the Client, as that would be duplicative of the services already available in an institutional setting.

These visits are an important component of the Client's Behavior Support services; however, the Behavior Support Provider cannot bill for these visits until the ECS/SBS Client moves into (or returns to) the residential setting.

When an ECS or SBS Client is authorized to receive services under the RSW, the assigned Case Manager will follow the Region-to-Region transfer process. Coordination includes identifying contact person(s) for communicating intent to transfer and coordinating with the residential provider and Behavior Support Provider services.

Clients eligible for ECS or SBS may receive both Behavior Support services and outpatient mental health services through the MCO to maintain their community residential setting, if needed.

Document the name and contact information of the Client's Behavior Support Provider and outpatient Mental Health services provider (if applicable) on the Contact Details CARE screen.

Note: Individuals accessing a Behavior Management Plan provided through a local community mental health provider (i.e. – PACT, IRT, SUD, out-patient mental services) are not eligible for ECS or SBS. This provision is created for instances where a Client declines a Behavior Support Provider referral in preference of a Behavior Management Plan from a community mental health provider. In this case, the CARE assessment must reflect the use of "Mental Health Therapy/Program" in the Medical Treatment section.

Case Managers must ensure that Behavior Support Provider services are not authorized when community mental services are providing a Behavior Management Plan to avoid duplication of services.

WHAT OTHER SERVICES ARE OFFERED UNDER THE RSW?

Adult Day Health (ADH)

Nursing, or rehabilitative therapy, services are available for Clients with medical or disabling conditions that require interventions or services from a registered nurse, licensed speech therapist,

occupational therapist, or physical therapist under the supervision of the Client's physician, when required. The need for ADH services must be identified in the Client's PCSP. Example – an ESF Client is eligible for speech therapy from an ADH center because the Client's assessment indicates this is needed.

ADH services may not duplicate any other Medicaid service received by the Client. See Chapter 12 of the LTC Manual for more information on ADH.

Wellness Education

Wellness Education supports Client health literacy and Client engagement in healthcare. This service is provided by Smart Source. If a Client chooses to receive Wellness Education, it may be authorized for one unit per month using Service Code SA080. Wellness Education provides targeted information based on the individual's CARE details and is mailed to the individual's address.

Note: the start date for this service can be between the 1st and the 20th of each month. If the start date will be after 7:00pm on the 20th, the start date should be the first of the following month.

Wellness Education is available in 28 languages, based on the Client's preferred written language in CARE. Some Clients indicate Braille in CARE but prefer to have Wellness Education read to them. If a Client with visual impairment wants Wellness Education in Braille, please contact the Wellness Education Program Manager to have the Client added to the list for Braille transcription.

Wellness Education Newsletters are offered in the following languages or formats:

Albanian	English	Large Print	Somali
Arabic	Farsi/Persian/Dar	Moldavian/Romanian	Tagalog
Amharic	Hindi	Punjabi	Thai
Armenian	Ilocano	Russian	Tigrinya
Braille	Japanese	Samoan	Ukrainian
Cambodian/Khmer	Korean	Serbo-Croatian	Urdu
Chinese	Lao	Spanish	Vietnamese

QR Code read-out (Added 2025)

Specialized Equipment/Supplies and Durable Medical Equipment

Specialized Equipment and Supplies (SES) are non-medical equipment and supplies that are not covered by Health Care Authority, such as waterproof mattress covers, handheld showers (when used by the caregiver), urinals, and portable ramps that don't involve any structural modifications to the Client's home. These items are:

- Necessary to increase the Client's ability to perform activities of daily living; **or**
- Necessary for the Client to perceive, control, or communicate with the environment in which the Client lives; **and**

- Of direct remedial benefit to the Client; **and**
- In addition to any medical equipment and supplies provided under the Medicaid State Plan, Medicare or other insurance.

Maintenance and upkeep of items covered under this service are also available, as well as training for the Client and caregivers for how to operate and maintain the equipment. Items reimbursed under RSW exclude items that are not of direct medical or remedial benefit to the Client; items requested that are not of a direct medical or remedial benefit are limited to $700 per occurrence without an ETR.

Durable Medical Equipment (DME) as defined under Chapter 182-543 WAC include items which are:

- Medically necessary under WAC 182-500;
- Necessary to increase the Client's ability to perform ADLs, or to perceive, control, or communicate with the environment in which the Client lives;
- Directly medically or remedially beneficial to the Client; and
- In addition to, and do not replace, any medical equipment and/or supplies otherwise provided under Medicare and/or Medicaid.

Refer to LTC Manual COPES Chapter 7d for additional directions on durable medical equipment, including how to authorize this service.

Nurse Delegation

This waiver service is authorized under RCW 18.79.260 and Chapter 246-840 WAC, and is available in AFHs with either an SBS or ECS contract. **This service is not available in ESFs or ALFs.** Nurse delegation can be provided in ALFs by the facility nurses. When the ALF provides nurse delegation, it is included in the ALF rate and is not authorized by the Social Services Specialist.

Under Nurse Delegation, a Registered Nurse (RN) delegates specific nursing care tasks, which are normally done by a nurse, to a qualified long-term care worker or caregiver who has completed the required training and is able to demonstrate that they are competent to perform the tasks to the satisfaction of the delegating RN.

For more information on nurse delegation, please see Chapter 13 of the LTC Manual.

Private Duty Nursing Services

This state plan service is available in AFHs, provided it does not duplicate nursing services included in the residential service. **It is not available in ESFs because nursing services are already provided in this setting.** Private Duty Nursing (PDN) is a program that provides in-home or Adult Family Home based skilled nursing care to Medicaid Clients 18 years of age and over who would otherwise be served in a Medicaid Medical Institution (MMI). Home and Community Services (HCS) is responsible for this service. PDN is an alternative to institutional care and is the program of last resort.

For more information about Nursing Services, including referral process and resources, see LTC Manual Chapter 25 Private Duty Nursing.

Nursing Services

This is not a specific waiver service but is available to RSW Clients per RCW 74.09.520 (2) (b) and (c) and is available in AFHs with either an SBS or ECS contract. **This service is not available in ESFs.** Nursing Services offer Clients, providers, and Case Managers, health-related assessment and consultation to enhance the development and implementation of the Client's plan of care. These services are provided as an administrative function. This service does not require an authorization in ProviderOne since HCS and AAA nursing staff provide this function.

For more information about Nursing Services, including referral process and resources, see LTC Manual Chapter 24 Nursing Services.

WHAT IF A RSW CLIENT WANTS TO MOVE?

If a RSW Client wants to voluntarily move out of the community residential setting or private setting, the Case Manager will work with the Client and provider to address any related issues, and work with the Client to find another community setting option. If case management responsibilities are transferred to another Case Manager, the former and current Case Managers will coordinate to ensure a smooth transition for the Client. CCG services may help an individual transition to a community setting of choice and receive RSW services in that setting, if eligible.

CAN A RSW CLIENT RECEIVE COMMUNITY CHOICE GUIDE (CCG) SERVICES TO SUPPORT MOVES AND TRANSITIONS?

Yes. It is the responsibility of the Client and case manager to determine the appropriate setting and RSW service; setting determination may not be assigned to a CCG, though after the setting is chosen the CCG can support the Client's move to that new community setting.

Community Choice Guide (CCG)

Community Choice Guide (CCG) Community Choice Guide (CCG) services can be authorized to Clients enrolled in RSW to establish or stabilize a person currently in a community living arrangement including a licensed residential setting, such as an adult family home or assisted living facility, or in a private residence. Individuals are eligible for CCG services when the person's community living situation is unstable and the person is at risk of institutionalization. Examples include if a Client is experiencing:

- Frequent institutional contacts (ER visits, SNF stays, hospital admits, etc.).
- Frequent turnover of caregivers resulting in an inability to maintain consistency of care.
- Threat of imminent eviction or loss of current community setting.

CCG services in RSW to assist the eligible RSW Client to live in the community setting of their choice by:

- Identifying needs and locating necessary resources to establish and achieve successful integration into the Client's community setting of choice.
- 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 options, household budgeting, and other needs identified in care plan.
- Supporting the establishment of networks of relevant Client partners: nursing or institutional facility staff, case managers, community providers (including AFH, ALF and ESF providers), medical personnel, legal representatives, paid caregivers, family members, housing agencies and landlords, informal supports and other involved parties.
- Ensuring all necessary paperwork and documentation is identified and completed to obtain and maintain Public Benefits and other services necessary for community integration.
- Assisting the Client in locating and arranging transportation to effectively connect with the community and community resources. An example would be a one-time purchase of a bus pass. Transportation for medical appointments should be provided by existing non-emergency medical transportation benefits if the Client is eligible.
- 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.
    - 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.
- Locating and arranging appropriate, accessible housing, including working with HCS Housing Resources, local housing authorities and other community resource providers and landlords, when applicable and authorized (see Chapter 5b for more information).
    - If Client needs more intensive, long-term support with housing than a CCG can assist with, see Chapter 30d for information on Foundational Community Supports-Supportive Housing.
- Assisting in finding a qualified caregiver (see Note below).

- Below are specific tasks a CCG can be authorized to assist the case manager with that are not a duplication of services. This information can be found in Chapter 11 of the LTC Manual.

Tasks a CCG can be authorized to assist the case manager

1. The CM will send the Assessment Details and Service Summary to CDWA through the standard file transfer process (through CARE) or via email to InfoCDWA@consumerdirectcare.com.

2. The CCG should be listed as a Collateral Contact if a CCG will be authorized to assist in locating an IP and the CCG copied on the email.

3. Authorized CCG tasks that could expedite posting of an ad when directed by a CM and the hiring of an IP, could include:

a. When directed by the CM, email CDWA at InfoCDWA@consumerdirectcare.com.

- Note: CCG should always copy the authorizing case manager when communicating with CDWA.
- Note: CDWA applies email filters based on the subject and key words to direct the email internally to CDWA's Client/IP Referral Support Team, so emails must use the exact subject lines below to communicate.

b. Subject lines for specialized needs:

- For Client's new to Medicaid Services use the subject line: "CDWA new Client / new to Medicaid services".
- For Clients who are discharging from an acute care setting or skilled nursing facility, has left a facility AMA, has APS involvement, or nursing/ wound involvement, use subject line: "CDWA urgent hire required".

c. If the IP is already a CDWA employee, the CCG can include the IP name, phone number, email, and mailing address in the email, if known.

d. If the IP is a brand-new IP, the CCG can include the IP name, phone number, email, and mailing address in the email (if known). Refer the IP to the "Careers" tab on the CDWA website to begin the hiring process.

e. The CCG can be authorized to assist the Client/AR with interviewing and hiring the IP, if authorized by the CM, including emailing the CDWA Client/IP Support Team of the Client's IP choice, copying the CM.

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.

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 or RSW scope of work.

Community Choice Guide – Issuing a Payment for AT Goods (SA266)

Assistive Technology (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. See CFC Chapter 7b for more information.

Based on a Client's eligibility:

- The case manager will supply the detailed information for the covered AT 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 AT after it is verified the Client received the AT Good. Authorization for the AT Good is under a separate service code and the case manager will process the reimbursement(s) for AT Goods to the CCG has provided an invoice/receipt as proof of purchase.

Community Choice Guide Service Codes:

- SA263 CCG (includes the most recent Activity Tracking Form)
- SA266 Issuing Payment for AT Goods

NOTE: Service providers, such as pest eradicators janitorial services, and packing/moving services must be performed by a contracted provider who hold 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.

Clients residing in King County:

Agency CCGs may have negotiated a different rate when performing authorized tasks for Clients who are residents of King County (SA263; see SCDS for more information). When authorizing services, confirm the correct contracted CCG rate has been selected for a Client who resides in King County. When the rate for an Agency CCG provider is county specific and a move has occurred that impacts rate (into or out of King County, for example), the service line should be modified prior to transferring the file following all instructions in the Social Service Authorization Manual (SSAM).

Community Choice Guide Provider Qualifications:

- Bachelor's degree in social work or psychology with two years' experience in the coordination of Independent Living Services (ILS).
    - Examples of ILS include working as a supported employment or supported living staff, peer trainer or mentor, volunteer or staff of an ILS Center, or similar where you teach and support individuals to maintain or learn skills to increase independence.
- Two years' experience in the coordination of ILS in a social service setting under qualified supervision.
- Four years of personal experience with a disability

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 CARE Web.
    a. Enter a brief comment for each treatment. Examples include:
        - **Community Integration**: CCG to assist with transitioning a Client to the community **OR** CCG to assist with stabilizing Client in the community.

- **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.

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 in Chapter 7d: COPES site.

NOTE: For more information on how to authorize CCG services please refer to the
For more information and guidance related to CCG services and authorization steps, please review Chapter 7d – COPES and the CCG Services SharePoint.

Community Choice Guide is one of the several stabilization services available to RSW participants. The Washington Roads service package may also be beneficial. See Chapter 5a for more information.

WHAT IF A RSW CLIENT NEEDS HOSPICE?

An RSW Client may receive hospice services as long as the hospice services are not duplicative of any service available under the RSW.

WHAT ARE THE CASE MANAGEMENT RESPONSIBILITIES REGARDING HOSPITAL DISCHARGES TO AN ESF?

When a Client chooses an ESF setting, the Regional RSW Team will coordinate with the ESF Administrator—who is contractually responsible for oversight of the facility—to ensure all needed services and supports are in place for the Client prior to the Client moving into the ESF. The ESF Administrator is responsible for coordinating with the local MCO to provide mental health services to the Client.

The Case Manager will work with the "transferring facility" (state hospital, psychiatric facility, or residential facility) to coordinate details such as medications, appointments with prescribers, equipment, legal issues, etc., in preparation for the Client's move into the ESF.

The Case Manager should be involved in all activities and planning for the Client's transition to the community and has the following specific duties:

- Review and approve the ESF provider's pre-admission assessment and transition plan prior to admission;
- Ensure the Client has an adequate supply of medications prior to discharge;
- Ensure the Client has an appointment with a medication prescriber in the community prior to discharge; and

When the Client is ready to move to the facility, the Case Manager or hospital assessor will:

- Authorize services;
- Notify the financial worker of the discharge date using DSHS Form 14-443; and
- Authorize the payment to the provider, effective the date the Client is to move into the facility.

As best practice, when a Client is transitioning to an ESF, the Case Manager must:

- Ensure Clients only move into an ESF at the beginning of the week (Monday-Wednesday);
- Visit the Client in the facility frequently (Based on Client's transitional needs)

- How frequently the Case Manager visits the Client is dependent on Client need and the required core and supportive functions of the Case Manager. For Case Management policy, please see LTC Manual Chapter 5: Case Management.
- Regularly review the Behavior Support Plans;
- Participate in the Client's PCSP Team meetings; and
- Conduct the initial Client visit within three business days of the Client transition into the ESF.

WHAT IF A RSW CLIENT'S LESS-RESTRICTIVE ALTERNATIVE (LRA) IS EXPIRING?

Any RSW Client who wants to transition from an RSW setting to another living situation should receive support and transition services from the Client's PCSP Team. If a Client is on a Less-Restrictive Alternative (LRA), the PCSP Team should begin the transition planning well in advance of the LRA expiration date. The RSW Client must be included in all discussions regarding transition planning.

WHAT ARE THE RESIDENTIAL PROVIDER MEDICAID CONTRACT REQUIREMENTS?

ECS Contract Requirements

To be eligible for the ECS contract:

- ALFs and EARCs must be licensed under Chapter 18.20 RCW and Chapter 388-78A WAC, meet all qualifications established within this RCW and WAC, and:
  - The license holder must be licensed with the State of Washington for twelve months preceding the application for an AL-ECS or EARC-ECS contract; and
  - The license holder and any affiliates must have no significant enforcement actions during the twelve months preceding the application for the AL-ECS or EARC-ECS contract.
- AFHs must be licensed under Chapter 70.128 RCW and Chapter 388-76 WAC and meet all qualifications established within the RCW and WAC. In addition, AFHs must meet the criteria and qualifications of the Expanded Community Services contract, and:
  - The AFH license holder must be licensed with the State of Washington for twelve months preceding the application for an AFH-ECS contract; and
  - The AFH license holder and any affiliates must have no significant enforcement actions during the twelve months preceding the application for the AFH-ECS contract.

An AFH or ALF Provider must complete ECS Contract Training (provided by the Regional Resource Specialist) prior to receiving the contract.

SBS Contract Requirements

To be eligible for the SBS contract, AFHs must be licensed under Chapter 70.128 RCW and Chapter 388-76 WAC, meet all qualifications established within this RCW and WAC, and:

- The AFH license holder must have a Washington State AFH license for at least 12 months prior to applying for this contract;
- The AFH license holder and any affiliations must have had no significant enforcement actions during 12 months prior to applying for this contract; and
- The AFH license holder must have a demonstrated history of successfully working with people with behavioral challenges.

Note: A demonstrated history can be either positive or negative. The HCS Regional Administrator may deny an SBS contract if the provider has a **negative** history of working with individuals with challenging behavior that includes any of the following:

- Not accepting Clients back when they go to the hospital;
- Frequently issuing 30-day discharge notices to Clients;
- A pattern of disregarding Client rights;
- A pattern of not complying with general AFH contract requirements;
- A pattern of not working with the contracted Behavior Support Provider; or
- Declining referrals for ALTSA assistance (RCS Behavioral Health Support Team and/or HCS Behavioral Support Training).

An AFH provider must complete SBS Contract Training (provided by the Regional Resource Specialist) prior to receiving the contract.

Note: An AFH with an SBS contract may only serve up to three SBS residents at any given time. One additional SBS resident may be authorized at the discretion of the HCS Regional Administrator, who must review the performance history of the AFH. If the AFH has a positive history and has had no RCS citations or RCS enforcement actions within the prior 12 months, the HCS Regional Administrator may authorize up to one additional SBS resident for the AFH. **An AFH may not have more than four SBS residents.** If the fourth SBS Client leaves or is discharged, any new SBS referral for the fourth SBS bed must be staffed with the HCS Regional Administrator. The HCS Regional Administrator will coordinate with the assigned Case Manager to submit documentation of the approval or denial of the specific fourth SBS resident. Documentation may be represented as either email confirmation of approval/denial or formalized regional letter.

CSS Contract Requirements

To be eligible for the CSS contract, ALFs must be licensed under Chapter 18.20 RCW and Chapter 388-78A WAC, meet all qualifications established within this RCW and WAC, and:

- The license holder and any affiliates must have no significant enforcement actions during the twelve months preceding the application for the CSS contract.
- The ALF must have the EARC **and** ECS contracts.
- The ALF license holder must have a demonstrated history of successfully working with people with behavioral challenges.

Note: A demonstrated history can be either positive or negative. HQ may deny a CSS contract if the provider has a **negative** history of working with individuals with challenging behavior that includes any of the following:

- Not accepting Clients back when they go to the hospital.
- Frequently issuing 30-day discharge notices to Clients.
- A pattern of disregarding Client rights.
- A pattern of not complying with general ALF/ECS contract requirements.
- A pattern of not working with the contracted Behavior Support Provider.
- Declining referrals for ALTSA assistance (RCS Behavioral Health Support Team and/or HCS Behavioral Support Training).

- Have demonstrated ability to provide or arrange for all required staff trainings.
- Ensure that qualified professionals are available as required by the CSS contract to provide direct services and supports to the Clients.

NOTE: Providers interested in contracting for CSS should contact the HQ Resource Support and Development team at ResourceDevelopment@dshs.wa.gov.

ESF Contract Requirements

To be eligible for the ESF contract, ESFs must be licensed under Chapter 70.97 RCW and Chapter 388-107 WAC, meet all criteria and qualifications within this RCW and WAC, and must:

- Have demonstrated experience providing services and supports to adults with challenging behavior;
- Have demonstrated ability to serve individuals whose criminal or behavioral history has kept them from being served in the community;
- Have demonstrated ability to provide or arrange for all required staff trainings; and
- Ensure that qualified professionals are available as required to provide the direct services and supports to the Clients.

NOTE: An ESF may accept private-pay residents. In doing so, the ESF:

- Nurse will need to assess the individual;
- Must determine, in advance, the payment/rate for private-pay status;
- Must have a clear, documented list of all charges for private-pay status that is provided to the resident;
- Must have a clear, documented list of all charges for private-pay status that is provided to the resident;
- Must have a clear, documented process for private-pay billing; and
- Must utilize an Admission Agreement to ensure the resident understands – and agrees to – why and how the resident's funds are being spent.

HOW ARE CONTRACTS MONITORED?

Contracts with residential settings Adult Family Homes (AFH), Assisted Living Facilities (ALF), and Enhanced Services Facilities (ESF) that provide Residential Support Waiver (RSW) services are actively monitored. This includes oversight of Behavior Support Provider (BSP) contracts.

The Home and Community Programs Contract Monitoring Team is responsible for monitoring contracts for Enhanced Community Services (ECS), Specialized Behavioral Support (SBS), Community Support Services (CSS), and Behavior Support Providers. Each team member is assigned to a specific region and collaborates closely with HCS Regional Administrators to prioritize which facilities or agencies will be monitored.

The RSW Program Manager oversees monitoring of ESF contracts.

To meet the AFH provider contract requirement for monthly meetings, monthly staffing between BSPs and Case Managers are considered sufficient.

Any concerns regarding contract compliance should be immediately staffed with the local RSW Supervisor to determine whether a referral to the Contract Monitoring Team or the Behavior Training/Support Team is appropriate. Referrals for contract monitoring may be submitted via email: **hcpcontractmonitoring@dshs.wa.gov**. Referrals for HCS Behavior Support Team for providers may be submitted via email: BSTRef@dshs.wa.gov

RESOURCES

Related WACs and RCWs

WAC 182-500	Medical Definitions
WAC 182-512-0050	SSI-related medical—General information
WAC 182-551-2100	Skilled nursing services
WAC 182-543	Medical Equipment, Supplies, and Appliances
WAC 246-840	Practical and Registered Nursing
WAC 388-106-0336	What services may I receive under the residential support waiver?
WAC 388-106-0337	When are you not eligible for adult day health services?
WAC 388-106-0338	Am I eligible for services funded by the residential support waiver?
WAC 388-106-0340	When do services from the residential support waiver start?
WAC 388-106-0342	How do I remain eligible for residential support waiver services?
WAC 388-106-0344	How do I pay for residential support waiver services?
WAC 388-106-0346	Can I be employed and receive residential support waiver services?
WAC 388-106-0348	Are there waiting lists for the residential support waiver services?
WAC 388-106-0355	Am I eligible for nursing facility care services?
WAC 388-107-0030	Admission Criteria
WAC 388-107	Licensing requirements for enhanced services facilities
WAC 388-76	Adult Family Home Minimum Licensing Requirements
WAC 388-78A	Assisted Living Facility Licensing Rules
RCW 18.20	Assisted Living Facilities
RCW 18.79.260	Registered nurse—Activities allowed—Delegation of tasks
RCW 70.97	Enhanced services facilities
RCW 70.97.030	Admission criteria
RCW 70.128	Adult Family Homes
RCW 70.129	Long-term care resident rights
RCW 74.09.520	Medical assistance—Care and services included—Funding limitations.
CMS [42 CFR 441.301(c)(2)]	Home and Community-Based Services (HCBS)

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
8/21/2026	JD Selby	• Added 5 RSW Care Eligibility Questions • Clarified Functional And Financial Eligibility • Updated ECS Alf Add On Service Code • Updated And Clarified CCG Per Regions' Recommendations • ECS Provider and CM Responsibilities • SBS Provider and CM Responsibilities • CSS Provider and CM Responsibilities • ESF Provider and CM Responsibilities	

		• ESF PCSP TEAM, ROLES AND RESPONSIBILITIES • ESF STAFFING • CSS STAFFING • CSS PROVIDER REPSONSIBILITIES	
4/7/2026	JD Selby	• Clarified Service code authorizations • Functional and financial eligibility • ESFs eligibility • Updated use of BMP, BEP	
7/14/2025	Jamie Tong	• Updated multiple chapter sections for grammar and flow in chapter per regional feedback. • Clarified Fast-Track process.	
07/01/2024	JD Selby	• Updated multiple chapter sections to reflect regional feedback to include: • Revisions for RSW referral process and regional contacts for RSW referral submissions and integration of State Hospital Discharge and Diversion (SHDD) teams for ESF & Community Stability Supports (CSS) service coordination, • Updates for RSW Committee review for eligibility and service determinations, • Revised language for RSW Fast Track utilization, • Updates to ECS and SBS Case Management and frequency of monitoring, • Integration of CSS services into RSW chapter, • Updates for Wellness Education newsletter language and formats, • Updates for provider contract requirements section to reflect current contracting agreements, • Updates for contract monitoring • Inclusion of July 1, 2024 1915i waiver/Community Behavioral Health Support (CBHS) service information to include: • Updates for management of Behavioral Health Personal Care (BHPC) and Managed Care Organization (MCO)	H24-046

		utilization of Behavioral Health Wraparound Supports (BHWS), • References for Chapter 22a for coordinating additional MCO behavioral supports, • Updates to CSS and ESF tier CARE authorizations • Corrected all broken or missing links • Added or updated attachments to the appendix: • Service Level Guidance For RSW-Eligible Individuals • RSW and EBS Eligibility Determination form • Repaired links for DSHS forms 11-130, 15-596 • RSW/EBS Referral Flow Chart • BHPC + RSW to CBHS Crosswalk	
12/14/2023	JD Selby	• Updated CMS approval for RSW renewal	H23-086
7/1/2023	JD Selby	• Updated "Ask the Expert" for current RSW Program Manager contact information • Chapter section updates for RSW Referrals, RSW Eligibility and Service determinations • Inclusion of Community Stability Supports (CSS) information • Based on regional feedback, provided clarifying language and references regarding ○ RSW referral and eligibility and service determination ○ Utilization of ALTSA and MCO-funded codes for ESF • Corrected all broken or missing links • Added attachments to the appendix: ○ Service Level Guidance For RSW-Eligible Individuals ○ RSW Referral Requirements Elements ○ RSW-SBS Staffing Schedule Template	

1/8/2020	Sandy Spiegelberg	• Minor content changes and updated to new format	
5/19/2020	Sandy Spiegelberg	• Clarify Wellness Education, add the RSW CFC Ancillary Fast Track RAC, and update the ESF Referral Process to replace the Clinical Review with a review by the Mental Health Nurse Program Manager	
11/1/2020	Sandy Spiegelberg	• Clarify the one-to-one additional support for SBS Clients, clarify the use of Behavior Management Plan or Behavior Evaluation Program, update how to access MCO funding, update the Resource list to include additional statutes and the licensing regulations, and update the Table of Contents.	
3/1/2021	Sandy Spiegelberg	• Change ECS monthly meeting requirement to as needed, but at least every six months; add financial eligibility language; clarify that AFH Providers are responsible for scheduling monthly SBS PCSP Team meetings; clarify the services provided by the Behavior Support Provider; and make formatting and grammatical changes	
8/1/2021	Sandy Spiegelberg	• Explain how an AFH can increase the number of SBS Clients from 3 to 4; add a limit of 4 SBS Clients per home; allow HCS regions to provide SBS staffing schedule examples to AFH providers; require AFHs to receive SBS contract training before receiving the contract; clarify the role of the contracted Behavior Support Provider; and make formatting and grammatical changes.	
3/1/2022	Sandy Spiegelberg	• Clarify that Case Managers must ensure SBS 1:1 staffing is hired before authorizing the service; clarify that a dually-credentialed staff of a Behavior Support Provider cannot bill for two services provided at the same time; provide guidance to HCS staff on AFH Provider eligibility for the SBS contract and the consideration of negative	

		history; provide ESF daily rate; identify contract monitoring responsibilities; and address hospice services for an RSW Client.	
6/1/2022	Sandy Spiegelberg	• Update Table of Contents; clarify steps to take when an ECS Client refuses services; add new example for SBS Staffing Schedule; add that providers must take ECS Contract Training before receiving the contract; clarify ESF referral process; add requirements for accepting private-pay residents in an ESF; and minor grammatical changes.	