# Assessment and Care Planning

Chapter 3 describes the intent and process of performing an assessment and developing a care plan.

#### Ask the Expert

For questions or clarification needs about the content in this chapter or self-directed care, contact:

Dru Aubert, ALTSA HQ

Care Management Unit Manager

206-348-2698 - [dru.aubert@dshs.wa.gov](mailto:dru.aubert@dshs.wa.gov)

For questions or clarification needs on limited English proficient persons, contact:

Linda Garcia, ALTSA HQ

Americans with Disabilities/Limited English Proficiency/Voter Registration Assistance Program Manager

360-968-9745 - [linda.garcia1@dshs.wa.gov](mailto:linda.garcia1@dshs.wa.gov)

For questions or clarification needs about the bed rail policy, contact:

*vacant*, ALTSA HQ

Ancillary Services Program Manager

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## Goals and Functions of the CARE Assessment

### What are the functions of an assessment?

To develop a plan of care with an applicant and/or current long-term services and supports recipient, the CM/SSS must:

* Perform an in-person interview with the individual requesting long-term services and supports, in their home or place of residence, or another location that is convenient to the individual;
* Obtain and review documentation/information;
* Document the individual’s abilities, resources, preferences, and goals;
* Assure that available supports are not supplanted; and
* Use the information to assist in determining eligibility for long-term services and supports programs.

#### Assist the individual to develop a plan that:

* Is person-centered by incorporating the individual’s choices, preferences, strengths, and goals;
* Identifies items and services, within resource limitations (acknowledging health and safety risk factors and personal goals) either by paid resources or other means;
* Provides clear instructions to caregivers of the individual’s preferences related to services within program limits;
* Makes providers aware of the client’s authorized services to determine if they can adequately perform the tasks assigned; and
* Makes appropriate referrals to community resources based on abilities, preferences and/or mandatory referral policy.

### What is the function of the CARE tool?

The state establishes eligibility for services using the Comprehensive Assessment Reporting Evaluation (CARE) tool. The CARE tool functions as an assessment, service planning, and care coordination tool and is used to determine program eligibility and establish the amount of care (daily rate or monthly hours) a client is eligible to receive. See [related WACs and RCW](#_Related_WACs_and) in the Resources Section for program rules that establish total hours and how much the department pays toward the cost of services.

The CARE tool is also used to document eligibility for other Community First Choice (CFC) and waiver services such as Personal Emergency Response Systems (PERS), home-delivered meals, Adult Day Care, Adult Day Health, environmental modifications, etc.

### HCS/AAA: Who is eligible for an assessment?

Individuals eligible for an assessment are adults, 18 years of age or older, who:

* Apply for Core long-term care services
* Are likely to be eligible for Medicaid nursing facility care/coverage within 180 days or voluntarily request an assessment to reside in a nursing facility assessment
* Apply for Aging Network services.

Assess these individuals without regard to financial eligibility and prioritize in the following order:

1. Individuals with an Adult Protective Services (APS) case who may need case management or other long-term services and supports
2. Individuals on Hospice
3. Individuals in a hospital or in the community and in jeopardy of imminent harm or institutionalization (hospitalization or nursing facility)
4. Individuals who are otherwise at risk of being in a nursing facility in their present situations
5. Residents of nursing facilities who have imminent discharge potential to a community-based setting; and
6. All other requests for services.

### Who completes the CARE assessments?

**HCS:** The Home and Community Services (HCS) Social Service Specialist (SSS) or Nursing Care Consultant (NCC) completes:

* All Initial assessments.
* *EXCEPTION: Asian Counseling and Referral Service (ACRS) and Chinese Information and Service Center (CISC) complete Initial assessments in King County for specific ethnic populations*
* Annual and Significant Change assessments for individuals residing in residential settings
* Nursing Facility Level of Care (NFLOC) evaluations unless case managed by the Area Agency on Aging (AAA) or the Developmental Disability Administration (DDA). HCS should coordinate with AAA or DDA as needed to determine NFLOC (see [Chapter 10](https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual) for more information on Nursing Facility Case Management and Relocation)
* New assessments of former Aging and Long-Term Support Administration (ALTSA)-funded clients. (Individuals who have been terminated from all ALTSA services for more than one year and are requesting services again)
* New assessments for individuals currently on non-Core services applying for Core services; and
* New assessments of individuals requesting Adult Day Health only.

**APS or HCS (based on regional office protocol):** APS staff complete assessments for protective services.

**AAA:** The AAA/Aging Network Case Manager (CM) or nurse completes assessments for individuals:

* Receiving ALTSA-funded long-term services and supports in their home after services are initially authorized
* Moving from their own home to a residential or nursing facility setting
* Veteran Directed Care (VDC) assessments for participants in the VDC program
* On non-Core programs with the Aging Network, and
* Receiving Adult Day Health only after services are initially authorized.

**DDA:** DDA Case Resource Managers (CRM) complete assessments for individuals who are DDA-enrolled and receiving services funded through DDA, for children under the age of 18 who are not DDA enrolled but are eligible for personal care services, or for an individual being screened for a move to a nursing facility by DDA.

### Types of CARE Assessments

#### When do I complete an Initial assessment?

Complete an in-person Initial CARE assessment with an individual who requests Core services from ALTSA for the first time or for clients who have been terminated from all ALTSA-funded services for more than one year and are requesting services again.

#### What is an Initial/Reapply assessment?

This is an in-person CARE assessment for clients who are reapplying for Core services within one year of the last in-person assessment.

#### When do I complete an Annual CARE assessment?

* To continue to obtain federal funding, the federal government requires an in-person assessment to be performed at least annually to determine program eligibility. A new in-person assessment must be performed and moved to *Current* by the last day of the same month the previous in-person assessment was moved to *Current*. The Plan Period for each assessment is displayed on the Assessment Main screen.
* Services may not be authorized on a pending assessment. The assessment must be moved to Current before services can be authorized.

#### When do I perform a Significant Change assessment?

A Significant Change assessment is necessary to assess changes in client condition so the plan of care can be revised to reflect updates in care tasks and caregiver instructions. Perform an in-person, Significant Change assessment when there has been a reported change in the client's cognition, Activities of Daily Living (ADLs), mood and behaviors, or medical condition that will affect the care plan. The reported change may be an improvement or a decline in the client’s condition. Always use the Significant Change assessment when assessing a client in-person, within the current plan period, even if there is no change in the client’s condition. On the Assessment Main screen “Reason for Assessment” field, indicate the reason for the Significant Change assessment.

Significant Change assessments should be completed (moved to *Current*) no later than 30 calendar days from the date it is determined that there has been a change in the client’s condition that warrants a new assessment.  If the 30-day timeframe is exceeded, a reason must be documented in a Service Episode Record (SER).

AFH providers who submit a written request via fax, e-mail, or mail to the SSS/CM of a change in the client’s condition that warrants a Significant Change assessment, may request a review from the department when the assessment results in an increased daily rate but was not completed within 30 *calendar* days of receipt of a fully completed Form “*AFH Resident Significant Change Assessment Request”* and updated Negotiated Care Plan. If a review is requested, and the department determines the assessment was not completed within 30 *calendar* days due to department error, the increased daily rate must be authorized starting the 31st day from receipt of the written request.

When all required information has been received, the SSS/CM will use the “**AFH Sig Change Request**” SER code in CARE and enter the date the complete written request was received. (CARE will then generate a tickler to send reminders on the 20th and 27th calendar day from the written request date to complete the assessment and move it to Current.)

In some HCS/AAA cases, completion of an in-person, Significant Change assessment can determine the date of the next annual reassessment. For example:

* You complete (move to *Current*) a client’s Initial assessment on July 6, 2023, which means the Annual assessment must be completed on or before July 31, 2024.
* You complete an in-person, Significant Change assessment on October 15, 2023. This client’s Annual assessment date could be changed and would need to be completed on or before October 31, 2024. Additionally, you must confirm that the client is financially eligible before extending services for 12 months.

**In some cases, the change in the client’s condition may be temporary. If the change appears to be temporary do not assume the next in-person assessment will be an Annual assessment. Depending on the client’s situation you may need to reassess the client prior to a year for appropriate service planning.**

#### When do I perform an Interim assessment?

Perform an Interim assessment (for in-office use only. Never use for in-person assessments) when:

1. Making changes to assessments that do not involve a reported change in the client’s cognition, ADLs, mood and behaviors, or medical condition. This may be the result of:
   1. Additional information about the client that is **not** related to a change in the client’s condition
   2. A change in the availability of an informal support, or
   3. A correction of coding, for example, as a result of a Quality Assurance (QA) or supervisory review.
2. Documenting changes to the client’s condition that do not change the CARE Classification and the client is not planning to discharge from a skilled nursing facility.
   1. Information may be gathered via phone by the nurse/CM/SSS from:
      1. the client or the client’s representative,
      2. medical professionals,
      3. personal care providers, etc.
   2. Discuss and document the client’s reported changes using the appropriate and consistent lookback periods.

**NOTES on Interim assessments:**

* The reason for the Interim assessment must be documented on the Assessment Main screen in the “Reason for Assessment” field.
* Triggered Referrals screen:
* Follow up on any indicators that are relevant to the documented change in client’s condition (reason for the Interim).
* Indicators may be marked “No” in the “Refer?” dropdown if the Triggered Referral screen was completed at the previous in-person assessment.
* Completing an Interim assessment will not restart the plan period, and an in-person assessment will need to be completed before the plan period expires. If an in-person Significant Change is completed, the plan period will restart and another in-person assessment will be due within 365 days.
* **IMPORTANT:** An in-person Significant Change assessment must be completed when the:
* Interim assessment results in a **change in CARE Classification**. **The Interim assessment must be moved to *History* and a Significant Change assessment completed in the client’s residence**; or
* Client plans to discharge from a skilled nursing facility.

### Can a nursing referral result in a Significant Change assessment?

Yes. The nurse/CM/SSS may perform a [Significant Change assessment](#_When_do_I) as a result of the [Skin Observation Protocol](https://www.dshs.wa.gov/altsa/home-and-community-services/nursing-services) or a nursing referral when one or more Critical Indicators are triggered.

### Who uses the Veteran’s Directed Care (VDC) assessment?

AAA staff use the VDC assessment type for Veteran Directed Care program participants.

### What is an AAA/Non-Core assessment?

An AAA/Non-Core assessment is used by AAA staff when assessing a client for non-Core services, under the Senior Citizens Services Act (SCSA), Older Americans Act (OAA), or under locally funded services when providing Aging Network case management.

### Can I assess an individual who is in jail or prison?

Individuals in a jail or prison in Washington are considered residents of the State of Washington. Medicaid financial eligibility determinations can be initiated while an individual is in either a jail or prison facility. The individual, representative, or staff at the jail/prison can be provided with an Application for Benefits or directed to the online application. Applications should be submitted as soon as the individual knows of a potential release date.

Referrals for individuals in jails will follow the regular intake process. Social Service Specialists or nurses may go into jails or prisons to conduct assessments but will need to comply with the security requirements of the jail/prison facility. This may include submitting information for a background check, as well as making specific arrangements with the facility to bring a laptop computer into the jail/prison (this often requires specific security clearance).

Social Service Specialists or nurses should coordinate closely with the jail or prison facility staff to ensure access is provided to:

* the individual,
* staff who work with the individual (such as counselors or medical staff),
* and the individual’s medical and behavioral records.

Note: If a client is receiving a Non-Core SCSA or OAA-funded service and then applies for Core ALTSA long-term care services, HCS staff may perform an assessment using the last assessment (via “copy & create” function) that was done by the Aging Network. This process builds upon the assessments that were previously completed and facilitates the exchange of information regarding the client’s past functioning.

## Adding a client to CARE

Once you receive a request for an assessment, you must perform an intake, assign the case, and follow-up with clients to schedule the assessment within the required timeframes.

|  |  |  |
| --- | --- | --- |
| TIMEFRAMES | | |
|  | **For all applicants**  **(except hospital):** | **For applicants currently in an acute care/community psychiatric hospital:** |
| **Intake** | Enter applicants into CARE within 2 working days of receipt of referral. | Enter applicants within 1 working day. |
| **Assignment** | Intake Specialist will make 2 attempts to reach client by phone on 2 consecutive working days. If unable to reach client, Intake will mail [10-day letter](http://intra.altsa.dshs.wa.gov/hcs/translations/10DayFormLetterTranslations.htm) to client. Assign a primary case managerwithin one working day of conducting the initial Intake phone interview.  If no response after 10 days, case will be inactivated. | Assign the case so that the case manager has adequate time to make contact with the individual. |
| **Contact** | Case manager will make 2 attempts to reach client by phone within 3 working days of assignment. If unable to reach client, CM will mail [10-day letter](http://intra.altsa.dshs.wa.gov/hcs/translations/10DayFormLetterTranslations.htm) to client. If no response after 10 days, case will be inactivated. However, priority must be given to those individuals in jeopardy of imminent harm or in a nursing facility. | Make contact within 2 working days of receipt of referral to schedule an assessment and review Long-Term Services and Supports (LTSS) options regardless of desired discharge setting. |
| **Completion** | * From date of intake: Complete the assessment (move to *Current* and authorize services) within 45 days after the date of intake. * From CARE assessment creation date: Once the assessment has been initiated, it must be finalized (moved to Current) within 30 days. | * Assessment start date must be seven days from the date of referral or from the date the client is stable and predictable. * Complete the assessment (move to Current and authorize services) within 30 days of the date of receipt of referral. |
| ***Exceptions*** *to this timeframe may occur when:*   * *The client requests a longer response time;* * *The client is not available for an in-person contact;* * *There is difficulty in finding an appropriate and qualified provider;* * *Financial eligibility has not been completed; and/or* * *Coordination is needed with interpreter services.*   *When the required response time is not met, document the reason for the delay in a SER and describe what follow-up will occur.* | | |

### How do I add a client to CARE?

Determine whether the client is already in CARE using a unique identifier such as a Social Security Number (SSN). This will prevent creation of a duplicate client in CARE. Having a duplicate client in CARE will create problems when linking the client to ProviderOne. If the client does not exist in CARE, add the client to the system and complete the following screens:

1. Client Details
2. Overview: Assign a primary case manager and supervisor.
3. Residence: select the client’s Residence Type from the dropdown list and enter the client’s residence address[[1]](#footnote-1). If the mailing address is the same, mark the appropriate checkbox. **Do not delete historical residence records. If the client has moved, create a new residence record.**
4. Client Contact: if the client’s mailing address is different than their residence address, indicate the mailing address and contact phone numbers.
5. If the client uses email, enter the email address in the field provided.
6. Collateral Contacts: add all appropriate collateral contacts. If the client did not self-refer, identify the referent here.
7. Financial: Intake may obtain financial information, but the assessor must verify that the client is financially eligible at the time services are being authorized.
8. ProviderOne: link client to correct ProviderOne (P1) record. IMPORTANT: Use caution when linking CARE and P1 records. Compare the demographic information in CARE with ACES (Name, Date of Birth (DOB), SSN must match exactly)[[2]](#footnote-2). ACES is the primary source for this information when linking to P1.

When attempting to link a record in CARE you may get a message that indicates there is no record, and you have the option to create a new record. Ensure all of the information has been entered correctly into your search and in CARE before creating a new record in P1. This is very important to avoid payment problems.

See the CARE Help File > Dashboard > [Desk-Aid for Preventing Duplicate Client Record Creation in P1](https://careweb.dshs.wa.gov/help/output/Dashboard.htm#desk-aid_for_pr) for details and instructions related to linking clients in ProviderOne.

### When do I inactivate a client record in CARE?

Inactivate a client record in CARE anytime a client has requested voluntary withdrawal from services or has been terminated because they are no longer eligible.

## Performing a CARE Assessment

The CARE tool is used for determining eligibility and benefit level, developing care plans, and authorizing services for individuals served by ALTSA and DDA. Please refer to the [CARE Web Assessor’s Manual](https://careweb.dshs.wa.gov/help/output/default.html#t=Welcome.htm&rhsearch=linking) for detailed policy and procedure for completing an assessment in CARE. See [Chapter 7](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/) and its subsections of the Long-Term Care Manual for policy and eligibility criteria for specific services available for eligible clients.

Functional eligibility for programs assessed in CARE are based fundamentally, upon the assistance an individual receives with personal care tasks. Assistance with personal care means physical or verbal support with Activities of Daily Living because of the individual’s functional limitations. This assistance is documented using the CARE tool.

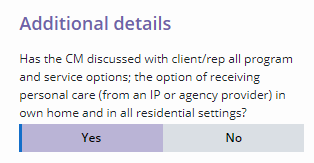
Assistance with personal care tasks is typically provided in the client’s residence but may also be provided while in the community if the client chooses. A common example of this would be a client wanting to attend a church or other organization but needs support with personal care while attending. This is supported in federal rules regarding person-centered care and community integration.

### Steps in performing a CARE Assessment

1. Contact the client to set up an appointment following [the contact timeframes](#_TIMEFRAMES). The following are suggestions:
2. If there is enough lead-time before the appointment, ask the client or their representative to have a letter from their healthcare provider listing their diagnoses.
3. Ask the client who they would like to attend the assessment appointment with them. Offer suggestions for who may be helpful in providing useful information.
4. Explain to the client that the appointment will take 2-3 hours. Assessment information will be requested from the client, facility records/staff (if applicable), and other collateral contacts as appropriate. Check for staff and client availability before the assessment (for residential clients, facility activities may limit the time the client is available for the assessment).
5. Let the client know you will be using a laptop or tablet and may need to work on a flat surface near an electrical outlet.
6. In addition to information already gathered (e.g., on an Intake form), screen for any potential hazards to the assessor.
7. On the day of the appointment, call to confirm.

**NOTE: If the client’s primary language is not English, follow the policy in** [**Chapter 15A/B**](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/) **for using an interpreter and translating documents.**

1. Assess the client in an in-person interview and gather information related to the individual’s functional abilities, goals, personal preferences, and any special instructions the caregiver may need to know to support the individual to complete tasks. At some point during the assessment request that the client speak with you privately in case they would like to share information for which they are not comfortable sharing in front of others. The assessment may be in pending status while you gather additional information to complete the assessment and care plan. During this time:
   1. Complete Consent Form [DSHS 14-012](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=14-012&title=). You must use this form to obtain, use, or share confidential information about a client in certain situations. Read the instructions on the Consent form carefully prior to assisting the client to complete the form and emphasize the information in the “notice to clients” section at the top of the form. Supplementing the consent form with the [DSHS Notice of Privacy Practices (03-387)](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=03-387&title=) is required at an initial assessment and is suggested for subsequent assessments to enhance the client/representative’s understanding of how and why information may be shared. Check the box “Other DSHS contracted providers.” SSS/CM staff should write in “ALTSA paid providers,” and CRM staff should write in “All DSHS Contracted Providers,” to cover the need to share information on an as needed basis, with providers paid by ALTSA or DDA-only. If there are specific questions about sharing information, consent and privacy, please contact the DSHS or ALTSA Privacy Officer.
   2. Gather Information
2. The client should be used as the primary source of information whenever possible.
3. Gather information from the client’s legal representative or substitute decision-maker, as appropriate. If the client has a guardian or DPOA, get this paperwork and forward to the Hub Imaging Unit (HIU) for imaging into the client’s electronic file.
4. Gather other information from collateral contacts if it is needed to complete the client’s assessment.
   1. Discuss Necessary Supplemental Accommodations (NSA). Individuals who have a mental, neurological, physical, or sensory impairment that prevents them from getting program benefits in the same way as those who are not impaired are considered in need of necessary supplemental accommodation. [Read more about NSA.](#_Necessary_Supplemental_Accommodatio_1)
   2. Review all [brochures and forms](#_Forms_and_Brochures) with the client. Also follow the [Self-Directed Care Checklist](#_Self-Directed_Care) for clients who would like to self-direct their services.
   3. [Assess for informal support](#_Assessing_Status_(Informal) available to fully or partially meet tasks identified in the client’s care plan.
   4. Complete the “My Goals and Plans” section on the Profile screen in CARE: Documenting and assisting clients to identify goals is an important part of person-centered service planning. Goals can identify what motivates a person, what is important to the person, and what are their desired outcomes regarding their care.
   5. For residential clients, document any modifications to client’s rights in a SER and in the comments section on the appropriate corresponding CARE screen for which the modification relates. See [Chapter 8](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%208.doc) for details.
   6. Review critical indicators from the Triggered Referrals screen. When possible, review while in the home with the client and/or representative as some have specific deadlines for follow-up. The following are some examples of when you would refer to or coordinate with nurses or make other referrals:
5. [Skin Observation Protocol](https://www.dshs.wa.gov/altsa/home-and-community-services/nursing-services) has been triggered. NOTE: The [[ALTSA skin breakdown prevention plan](https://www.dshs.wa.gov/altsa/home-and-community-services/nursing-services)](http://adsaweb.dshs.wa.gov/docufind/LTCManual/NursingServices/documents/PREVENTION%20PLAN%20FOR%20SKIN%20BREAKDOWN%20OVER%20PRESSURE%20POINTS03-05-03.doc)  will print on the client’s assessment details when potential skin issues exist.
6. Other critical indicators have been triggered (e.g., nutritional status affecting the plan of care).
7. Depression, Drug/Alcohol Abuse, Suicide, or Pain has triggered consideration of referrals.
8. Verify and Determine Eligibility. **Financial and functional eligibility must be determined concurrently** for clients receiving Core services (e.g., CFC, COPES, MPC, New Freedom, etc.). Communicate with financial staff regularly on status of financial eligibility and confirm financial eligibility has been established, complete Fast Track procedures as necessary. Document financial verification on the Financial screen in CARE or forward documents to HIU for imaging into the client’s file before authorizing or re-authorizing services for a new plan period. Develop a proposed plan of care with input from the client and relevant parties and if appropriate, hold an interdisciplinary case staffing to discuss the proposed care plan given a client’s particular situation.
9. Have a discussion with clients and present all the programs and services for which the client may benefit based on their needs, goals, and eligibility. Consider any assistive technology that may assist a client to be more independent with performing ADLs, IADLS, or health related tasks. Coordinate and plan for chosen services and supports and document in the client’s plan of care. See relevant [Long Term Care Manual Chapters](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/) for policy and eligibility criteria for specific programs and services available for eligible clients.
10. Have a discussion with clients regarding their choices related to long-term care settings and in-home personal care provider types (an Individual Provider through the Consumer Directed Employer (CDE) or a Homecare Agency provider). Clients should receive enough information about the settings and provider types available to them to make an informed choice of providers.
11. Document the discussion from #4 and #5 above in the Care Plan screen in CARE.



1. Assist clients in identifying a qualified provider. If a client has a difficult time identifying a provider, assist the client to identify barriers preventing the selection of a provider and to resolve issues that may be preventing service delivery. Ensure the client is familiar with the CDE and can access Carina. Check in with the client regularly and assist as needed. If a client is having challenges but is actively seeking a provider, do not terminate a client for the reason of not having a qualified provider.
2. If requested by client/representative, review the plan of care with potential providers.
3. If a client has chosen to have an assessment in a setting other than their home or residence where services are being provided, a visit must be made to the client’s residence before the assessment is moved to Current, or within 30 days of the assessment being moved to Current when extenuating circumstances are noted in a SER.

**Behavior Screen indicator related to Community Behavioral Health Support (CBHS) Services/**

**1915i (effective 7/2024)**

These services are currently available to clients in Adult Family Homes, Adult Residential Care Facilities, Enhanced Adult Residential Care Facilities, Assisted Living Facilities and Enhanced Service Facilities. For clients residing/seeking services in these settings:

During the CARE assessment, while providing the client with Home and Community Based Services (HCBS) and options, also provide the client with the CBHS brochure (HCA Form [19-0087](https://www.hca.wa.gov/assets/free-or-low-cost/19-0087-community-behavioral-health-support-services.pdf)). Based on selected diagnoses, a client may be eligible for Community Behavioral Health Support Services. If your client is interested in these services, the SSS/CM will review the assessment and for potential CBHS eligibility. If it seems the client is eligible on the Behavior Screen in CARE, update the question “Was a referral made for CBHS/1915i eligibility?” to “Yes”. See [Chapter 22a](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2022a.docx)/Apple Health Managed Care and Apple Health Medicare Connect (D-SNP) of the LTC Manual for more information on Community Behavioral Health Support (CBHS) services.

### Not eligible for Core services?

If a potential client is found to be ineligible for Core services:

1. For clients who may benefit from Family Caregiver Support Services, refer them to the local AAA
2. For clients over 60, consider a referral to the local AAA office or their partners for Community Living Connections (formerly Senior Information & Assistance)
3. Move the assessment to history
4. Send a Planned Action Notice and
5. Inactivate the client within 14 days unless an administrative hearing is requested

### Limited English Proficient Persons

Use the Demographics screen in the Client Details section in CARE to document the client’s language details. See [Chapter 15A/B](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/) for specific details related to clients who have limited English proficiency.

### Assessing Status (Informal Supports)

#### Background

As part of the waiver approval process and Code of Federal Regulations (CFR) related to person-centered planning, the Centers for Medicare and Medicaid Services (CMS) require the state to not replace naturally occurring supports with federal funds. One of the purposes of the assessment is to determine availability of informal supports and other non-department paid resources and community resources. Identified informal supports are based on voluntary action and are available so long as the source is willing and able to continue them. The state will inform clients, families, and support systems of options to address needs a client may have for unscheduled tasks and/or supervision beyond the number of hours authorized in an in-home care plan, including residential or nursing facility care (if applicable).

As the employer, the client/representative should determine the provider’s schedule, which is then documented by the case manager. When requested by the client or their representative, the schedule may be facilitated by the case manager with input from the client, formal and informal decision makers. The department is obligated to pay for hours worked up to the maximum number authorized in the plan of care.

#### What are examples of informal supports?

Informal supports are any resources available to fully or partially complete individual ADL and IADL tasks identified in the client’s care plan. Examples of informal support resources may include family members, friends, church groups, neighbors, Adult Day Health or Adult Day Care (because it is paid through a different DSHS funding source), hospice services, doctor’s office services for certain treatments/foot care, home health, congregate meals (served at senior centers, tribal centers, community center), etc.

#### Process of Determining Status

For each task, status indicates the degree of unmet need (anticipated informal/non-ALTSA/DDA paid support) looking forward, regardless of what the status was in the past.

Coding of informal supports are based on an individualized assessment of each ADL/IADL, considering any informal support that is willing and able regardless of the client’s living arrangement. No assumptions must be made about informal supports. Determinations are based on an individualized assessment of each client.

#### Special Considerations

* An Individual Provider (IP), who is paid by the CDE to provide care to an ALTSA/DDA client, may not be considered a source of informal support.
* If an individual requires two-person assistance every time the ADL is performed and only one informal support is available, then the status would be unmet.
* Consideration may include whether the client has unusually high needs for assistance with tasks that may offset a deduction to *Status* if some informal support is available Do not consider assistance with ADLs that will occur less than weekly, except for *Locomotion Outside of Room*.
* Do not consider assistance that will be provided by children under the age of 18.

#### When is the status “met”?

If the informal support(s) is willing and able to fully complete an activity (ADL or IADL) identified in the care plan on an ongoing basis, the status is considered “met.”

When is the status “partially met”?If the informal support is willing and able to provide some, but not all assistance with an activity (ADL or IADL) identified in the care plan on an ongoing basis, the status is considered “partially met.” If partially met is chosen, the assessor will need to identify the level of assistance available. Use the [Assistance Available](#assistavail) chart to determine the percentage.

When is the status “unmet”?

When there is no informal support available to assist with the activity (ADL or IADL), the status is considered “unmet”.

**Note:** If the client uses Paratransit or other public transportation but also requires an ALTSA-paid caregiver to assist with transfers, locomotion outside of room, and/or cognitive needs, the status may be “unmet” for Transportation. If the client does not need an escort, code Status based on provision of the transportation only.

[Medicaid brokerage services](https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/transportation-services-non-emergency) must be considered when determining whether or not to assign transportation to a personal care provider.

#### Assistance Available

Use this chart to determine what portion of a task is “partially met” by an informal support:

* Less than ¼ of the time
* ¼ to ½ of the time
* ½ to ¾ of the time
* More than ¾ of the time



j0391752**How do I know when I’m ready to complete CARE?**

Does your assessment meet the [minimum standards](#_Minimum_Standards) requirements? If yes, you are now ready to complete your CARE assessment.

### Finalizing a CARE Assessment – Developing the Plan of Care

#### Background

Clients can choose from options for personal and healthcare services that are governed by eligibility criteria, payment source requirements, coverage options, and provider qualifications. Twenty-four-hour, paid care is available only in residential or medical facility settings, so case managers must work with clients to maximize all available resources, both paid and unpaid, to develop a plan of care that addresses the health and safety needs of the client. The state identifies the essential tasks to be performed by formal providers in the care plan within program limits. How and when they are performed is determined by the client.

The state has an obligation to educate clients, family members, support systems, and other service providers, informing them that a plan of care is developed based on the resources available and that meeting all needs and providing all services is an expectation that neither the client, family, support system, or case manager may be able to achieve.

#### How do I get approval on the plan of care from the client?

Before authorizing services, you must [obtain the client’s approval](#_Getting_approval_on) on the plan of care and finalize the assessment by moving it to Current status.

#### How do I distribute the plan of care to the client/representative?

Distribute the Service Summary to the client along with a Planned Action Notice (PAN) found in CARE. The Personal Care Results (PCR) or Personal Care Results Comparison (PCRC) will be attached to the PAN. If the PCR or PCRC does not print, attach the CARE Results. Distribute Assessment Details if requested by the client/representative.

Follow instructions for translating CARE documents in [Chapter 15A/B](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/) when the client has a written language identified in CARE other than English.

#### How and when do I distribute the plan of care to the provider(s)?

Mail, fax, or securely email the Service Summary and Assessment Details prior to authorizing/extending services and document the action taken in the SER. Distribute the Service Summary and Assessment Details to:

* CDE (through CARE)
* Agency providers
* Nursing services staff, if applicable
* Residential providers
* The nursing facility, for those residents who are seeking Home and Community Based Services
* Hospital Discharge Planners for those patients who are seeking Home and Community Based Services
* Adult Day Services providers
* Nurse delegators
* Supportive housing providers
* Community Choice Guides
* Client Training Providers

Document in a SER when you have distributed the documents and to whom.

#### Documenting potential risk in the Plan of Care

1. Document any potential client/provider risks not otherwise documented in CARE using the ‘General comments’ section on the ‘Comments’ screen in CARE Web.

* Document a client’s registered sex offender status under “Legal issues” in the Safety screen

*Each of these sections will print in the Assessment Details for the provider’s awareness*.

1. Document in the SER that the specific issue that may be a potential risk to a provider (or other residents in a residential setting) was discussed with the provider.

#### Plans of care that include Individual Providers (IPs) through the CDE

* If the client does not have an IP identified, have the client/rep contact Consumer Direct of Washington (CDWA) for assistance with Carina
* If the client does have an IP identified, have the client/rep refer the potential IP to CDWA to begin the hiring process
* Ensure CDWA is added to the Supports screen in CARE and has all relevant tasks assigned. (CMs do not need to wait until an IP is fully hired with CDWA to move the assessment to Current.)
* Except when there is an urgent personal care need, CDWA must have an open authorization before they can begin working with clients.
* CARE notifications from CDWA will let the CM know when an IP has been hired.
* HCS CMs must wait for the CARE notification to be sent from CDWA prior to transferring the case to an AAA.
* Clients will work with CDWA to assign the hours to an IP(s).
* As the managing employer of IPs, the client/representative should determine the service plan schedule and communicate their preference to the CDE.
* When requested by the client or their representative, the schedule may be facilitated by the case manager with input from formal and informal decision-makers.
* IPs have a work week limit (WWL) managed by the CDE.
* Supervision of the IP must be performed by the client or their representative. When a client or client representative is unable to supervise their employee, a plan for increased monitoring is documented on the Cognitive Performance screen in CARE by the case manager.
* It is the client/representative’s responsibility as a managing employer to review the plan of care with the IP. The client may use the IP’s copy provided by CDWA, or request a copy from the CM.
* HCS/AAA staff do not complete Character, Competence, and Suitability (CC&S) reviews for IPs. If a CM has a concern about a current or potential IP/Client pairing, this information may be shared with the CDWA by using the CDWA CM Hotline at 866-932-6468 or by sending an email to the appropriate CDWA supervisor, based on their contact list for CMs. All emails should be specific in their subject line. **For example:** Subject: Concerns with IP/Client pairing. CC&S may be needed.

### Getting approval on the Plan of Care

To authorize services, the assessment must be in Current status following the client’s approval of the plan of care. The client’s approval verifies their participation in the development of the plan and consent to services outlined in the plan. You must have documentation of approval from the client or duly appointed representative.[[3]](#footnote-3) Clients are considered legally competent unless deemed incompetent by a court of law. A reasonable effort must be made to have the client’s approval and signature on documents if there is no court order deeming them incompetent.

Even if client has an active DPOA or guardian, look to the client directly to make choices about Medicaid services, to the extent possible. A client may also choose a representative who is not a DPOA or guardian, to act on their behalf to make decisions about Medicaid services and supports. If the client can indicate their free choice to authorize a representative, the representative may be allowed to make decisions about the client’s Medicaid services. Identify the representative or DPOA/Guardian in the Collateral Contact Screen in the Contact Details screen in CARE Web.

Determinations of capacity are very fact-specific, and the necessary level of “capacity” may depend on the type of decision that is being made. There may be situations when a doctor has determined that a particular client does not have the ability to consent for purposes of a particular medical decision. But that client may still have sufficient capacity to participate in the person-centered planning process or designate a representative to help them with the process (and subsequent decisions about their Medicaid services)

If while during the assessment there is reason to believe that the client’s ability to participate in the assessment is significantly impacted, the SSS/CM should be cautious about accepting the client’s approval and signature. The SSS/CM should document the CARE SER, the basis for accepting the client’s approval or signature, including objective facts and observations to support that the client was engaged in the activity and understood what they were signing. It may be appropriate in these situations to staff the case with a supervisor and to consider consulting with your agency’s attorney.

**If an individual’s representative, is also the client’s paid caregiver, another person must assist the client as their representative for the purpose of care planning**. In rare circumstances when there is no other option, the SSS/CM may assist the client for the purposes of care planning only. When the SSS/CM is assisting the client for the purpose of care planning, the SSS/CM will indicate this in the client’s SER in CARE. This is different than plan of care supervision, the SSS/CM must never identify themselves as responsible for supervising the plan of care on the Cognitive Performance screen in CARE.

#### Obtaining signatures on the CARE Service Summary portion of the client’s plan of care

[42 CFR 441.540(b)(9)](https://www.law.cornell.edu/cfr/text/42/441.540) requires all person-centered service plans to “be finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation.” The Service Summary page in the plan of care within CARE is the document used by HCS and AAA to comply with federal person-centered service plan signature requirements.

Once a client’s CARE assessment has been completed and moved to Current, the SSS/CMs must sign and obtain signatures of the client and the personal care service providers who are assigned tasks in the plan of care on the CARE Service Summary. The client and provider may only sign a Current Service Summary. It must not be in Pending or History Status.

#### Client Signature

SSS/CMs must obtain the client’s signature on the CARE Service Summary for Initial, Initial/Re-apply, Significant Change and Annual assessments. **For Interim assessments**, follow the steps for [getting approval on the plan of care](#_How_do_I):

* + when there is a change in CARE generated hours or classification,
  + program change,
  + addition/deletion of a service, and/or
  + provider change.

SSS/CMs may continue to authorize services for a completed assessment using the client’s **verbal approval** until the client’s signature can be obtained, and the client’s physical, electronic, or voice signature must be obtained at the earlier date of 90 days from the assessment *completion* date, or before case transfer; however, verbal approval may not substitute for the client’s physical, electronic, or voice signature.

CMS requires a **person-centered approach** to work with the client to obtain their signature. **Examples of methods that may be offered include, but are not limited to:**

* Completing and moving the assessment to current in the home and obtaining the client’s signature electronically in a PDF document using your touch pad, mouse, or touchscreen.
* Using the e-signature feature in CARE supported by Adobe.
* Using the voice signature feature in CARE supported by AmazonConnect. (See voice signature instructions and script in the [Attachments](#_Attachments) section).
* Making an in-person visit once the assessment is completed and moved to Current.
* Obtaining the signature by mail (See instructions in the [Attachments](#_Attachments) section for setting up ticklers in Barcode).
* Utilizing supports identified by the client to assist them with reminders to return the signed form.

The client may agree to initiate or continue services without agreeing with the hours/daily rate. Document this in a SER and move the assessment to Current.

For LTSS in-home assessments, if a client requests fewer hours to be authorized than are indicated on the Care Plan screen, document this in a SER. Use the In-home *Personal care adjustments* field in the Care Plan screen in CARE to document the number of monthly hours the client is choosing not to utilize. Select, *Client voluntarily hour reduction* from the *Reason* dropdown. This will result in the adjusted number of monthly hours to print on the Service Summary.

For LTSS in-home assessments, indicate adjustments for waiver services and/or HQ approved personal care ETRs using the In-home *Personal care adjustments* field in the Care Plan screen in CARE. This will result in the adjustment to total hours to print on the client’s Service Summary. (For details about waiver deductions see [Chapter 7](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/))

If the client has chosen a signature method other than e-signature, send the client a copy of the Current Service Summary with the SSS/CM’s signature and a Planned Action Notice (PAN). The Personal Care Results (PCR) or Personal Care Results Comparison (PCRC) will be attached to the PAN.

If a client chooses electronic communication outside of the e-signature feature in CARE, a faxed or electronic scanned signature is acceptable. If the client prefers, use encrypted email to send the client a PDF version of the Service Summary and PAN/PCR/PCRC. As necessary or requested by the client via a signed *Notice and Consent of Communication via Text or Unencrypted Email* ([DSHS Form #27-156](https://www.dshs.wa.gov/office-of-the-secretary/forms)) on file, the client may consent to receiving unencrypted email messages.

If the client chooses mail delivery as the method to obtain their signature, include an extra Service Summary with a cover letter and self-addressed, stamped envelope, so that the client can sign, date, and return the signed Service Summary.

If the client chooses voice signature, the CM/SSS may call the client using the Amazon Connect feature in CARE, to review the contents of the plan verbally and obtain the voice signature by phone. CARE will allow the assessment to be moved to Current while connected to a call. This would replace the need to obtain verbal approval prior to obtaining the signature. Upon completion of the assessment (assessment is moved from *Pending* to *Current* status), SSS/CMs need to send a copy of the SS to all clients, regardless of whether the client/representative chose to sign the SS via voice signature, and when needed, include the translated version of the SS to the client. Service Summaries for individuals whose signatures were obtained by voice signature, are typically not sent to the HIU for imaging. For LEP clients, the signed SS signature page *(in the translated version only*) should be sent to HIU. For detailed information and the script for obtaining voice signatures, see the instructions in the [Attachments](#_Attachments) section.

Document relevant approval/signature steps in the SER.

#### If it is not possible to obtain the client’s signature prior to authorizing/extending services:

1. Call the client to review the contents of the plan verbally and obtain verbal consent to receive the services that are documented in their plan of care.
   1. Document this conversation via CARE > Service Episode Record (SER) > *Plan Approval* purpose code; and
   2. Document that the client has participated in the development of the plan and verbally consents to the services.

Once the client has given verbal consent of the completed plan, work with the client to determine the best way to obtain their signature on the CARE Service Summary.

#### If a client does not return the signed Service Summary or refuses to sign the Service Summary:

Re-evaluate the person-centered approach used and work with the client/representative to obtain their signature. The approach used will depend on the individual and it may help to understand the reason for their resistance.

In some cases, a client may disagree with items identified in the plan or how they are worded and will not sign the plan. If this occurs, adjust the plan contents or wording. Clients may choose to delete certain information; however, if the information is determined to be necessary to address the health and welfare of either the client or the provider, discuss with the client and explain that unless the provider has this information, you may not be able to authorize services.

**Do not**:

* Include services on the plan for which the client is not eligible;
* Omit information that a caregiver must be aware of to determine that they can meet the client’s needs or provide care; or
* Omit information that could impact the health or safety of the client or provider.

If the SSS/CM is unable to obtain the client’s signature despite exhausting documented person-centered efforts, provide the following documentation in the SER in CARE:

1. The reason why the signature could not be obtained;
2. The person-centered approach and steps that were taken to obtain the client’s the signature;
3. A statement of the client’s verbal plan approval; and
4. What, if any, follow up will occur?

#### What to do when the client cannot sign

1. If the client appears to have capacity but physically cannot sign documents, the reason should be documented in a SER. Signing with an “X” or comparable mark is acceptable if it is witnessed by the CRM/CM/SSS or another party who has verified the client’s identity and has witnessed them signing the document.
2. If the client appears to not have capacity and is physically unable to sign documents but there is no DPOA or Guardian in place, the CRM/CM/SSS should state this in a SER. A guardianship may need to be considered for establishment of a formal decision maker for signing and consent purposes.
3. If the client does not appear to have capacity and there is no DPOA or guardian in place, all documents should be signed by the client and noted in a SER that the information was discussed with either the client or the client and their informal decision maker while identifying the informal decision maker in the *Collateral Contacts* screen.

#### Provider Signature(s)

1. SSS/CMs must obtain signatures on the CARE Service Summary from all providers who are authorized to provide personal care, at the earlier date of 90 days from the assessment *completion* date or before case transfer. The following personal care service provider types must sign the CARE Service Summary that is in Current status when the provider is added to the plan of care:

* Consumer Directed Employer
* Home Care Agency
* Adult Family Home
* Assisted Living Facilities
* Enhanced Services Facilities

1. SSS/CM must also obtain the provider’s signature when there is a change in their task assignment. For changes in providers during the plan period, SSS/CMs should obtain signatures at the earlier date of 90 days from the *authorization start date* or before case transfer.
2. Plans of care must continue to be sent to the provider prior to authorizing services.
3. All providers listed in #1 of this section are required to sign the Service Summary of the plan of care as required by CFR. Providers must return the signed Service Summary to the SSS/CM as soon as possible, using a method that protects the client’s protected health information (e.g. secure email, fax, mail etc.).

#### More about signatures

1. When the ONLY change to a client’s care plan is a change of a paid or unpaid provider:
   1. A new assessment may not be required
   2. A new client signature is not required
   3. A personal care provider signature may be required if there is a change in the paid task assignment
   4. The Service Summary in CARE must be updated and the updated version filed in the client’s electronic case record (ECR) via the HCS Imaging Unit (HIU). If the changes made do not require a signature, on the signature line, write “signature not required”.
   5. Print/send the Service Summary to the client and the provider and document the client’s request and consent for these changes in the SER.
2. Client and provider signatures must be obtained on Current assessments only. Signatures on plans of care that are in *Pending* or *History* are not valid approvals of the plan of care.
3. Obtain all required signatures prior to transferring a client’s case to another office.

There may be extenuating circumstances which prevent the SSS/CM from obtaining required signatures. In these rare situations, the local office must exhaust and document person centered approaches to obtain the required signatures and then discuss the matter with the receiving office directly, before transferring the case.

1. If there is more than one provider in the plan, it is acceptable to have the provider(s) sign in the blank space below the signature lines if they are signing the same copy.
2. Although it is ideal for all required signatures to be on one document, or as few documents as possible for the purposes of records management in the HIU, obtaining all required signatures is the most important priority. It is acceptable to have required signatures on separate Service Summaries stored in the HIU. If the complete Service Summary is sent to HIU prior to obtaining client and provider signatures and then the client or provider subsequently returns the signature page, staff do not need to send the entire Service Summary to HIU again. In this scenario only the additional signature pages would need to be uploaded to HIU.
3. Signatures may be in any format (e.g. written, electronic, stamp, typed, etc.) that denotes the signatory agrees to the plan of care. Signature means at least the signatory’s first and last name, but the CFR does not require a date or title. See instructions in the [Attachments](#_Attachments) section on using electronic signatures. Obtaining an electronic signature in the client’s residence has many advantages including:

* reduced or no ongoing tracking required
* in-person, person-centered review of the assessment with the client and/or provider to enhance understanding of the contents

1. Staff using the DSHS network can upload signed Service Summaries to HIU electronically and the document will be visible in the ECR within 24 hours. Local HCS and AAA offices will need to develop methods for monitoring and measuring the outcomes of the client and provider signature policy.

### Assessment Completion Timeframes

For all assessment types, the assessment must be moved to Current status by the 30th calendar day from the date the assessment was created in CARE.

If an assessment cannot be moved to Current within 30 days of the date it was created, document the reason in the SER. The Plan Period end date will automatically calculate using the last day of the month that the in-person assessment occurred. For example, if an assessment was created on 1/20/2022 and was moved to Current on 3/4/2022, 1/31/2023 will be automatically calculated as the Plan Period end date on the *Assessment Main* screen.

For Initial and Initial/Reapply assessments, CARE will require a delay reason be selected when the assessment is moved to Current after the 30th day.

These delay reason codes will be used in assessment timeliness reports and by ALTSA HQ to identify justifiable reasons that assessment completion may be delayed. When evaluating timeliness in reporting for ALTSA’s strategic measure, delay reasons will be considered.

|  |  |  |
| --- | --- | --- |
| CARE Delay Reason Codes for Initial and Initial/Reapply Assessments | | |
| **Code** | **Description** | **Examples** |
| **CR** | Client specific reason/request | * Difficulty reaching client for verbal approval after multiple attempts * Client changing mind about desired care plan * Client requesting more time |
| **FE** | Financial eligibility | * Financial eligibility not yet determined and fast track is not an option |
| **DO** | Awaiting documentation | * Awaiting medical records and/or treatment documents to complete assessment |
| **IP** | Individual provider | * Unable to identify qualified IP * Awaiting completion of IP hiring process through CDE |
| **AP** | Home Care Agency provider | * Awaiting homecare agency staffing |
| **RP** | Residential provider | * Difficulty locating and securing move to a residential setting |
| **TH** | Temporary hospitalization/SNF admit | * The client was temporarily admitted to a hospital or SNF and you are awaiting transition planning and/or plan approval. |
| **NR** | No other reason | * No other applicable reason noted here for assessment remaining in pending status |

### Significant Change Assessment by a Nurse

A nurse may conduct a home visit or consultation when a critical indicator or [Skin Observation Protocol](https://www.dshs.wa.gov/altsa/home-and-community-services/nursing-services) is triggered. Nurses will document concerns and recommendations via CARE > Nurse Comments, or a paper form, if they do not have access to CARE.

If the case is referred to the nurse and the assessment is in:

**Pending status:** the nurse can complete any screen using the original look-back periods for assessment data. The nurse would then consult with the CM/SSS regarding the assessment and/or recommendations.

**Current status:** The CM/SSS must decide who should initiate the pending assessment. If:

* The nurse creates a pending Significant Change assessment and completes applicable screens, after consulting with the nurse, the CM/SSS can complete the remaining screens with a client visit.
* The CM/SSS will create a pending assessment, initiate the assessment, then refer to the nurse for a visit and completion of the appropriate screens.
* Regardless of the nurse’s changes, the CM/SSS is responsible for moving the assessment from *Pending* to *Current* status.
* If the nurse wants a record of their changes, the nurse may print out the pending assessment after making changes or adding new information before returning the case to the CM/SSS.

### Significant Change Request by an Adult Family Home (AFH)

When a written request from an AFH provider demonstrates that there has been a change in a client’s condition that warrants a Significant Change assessment, the Department must complete the assessment within thirty (30) ***calendar*** days of receipt of a fully completed Form [15-558](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=15-558&title=) (AFH Resident Significant Change Assessment Request) and updated Negotiated Care Plan.

An AFH provider may request a significant change assessment by:

* Completing DSHS [15-558](https://www.dshs.wa.gov/sites/default/files/forms/pdf/15-558.pdf) *Adult Family Home Resident Significant Change Assessment Request* by providing complete and detailed information about the resulting change in the client’s condition and the care provided*;*
* Updating the Negotiated Care Plan with the changes noted; **and**
* Submitting the *Adult Family Home Resident Significant Change Assessment Request* **and** the updated Negotiated Care Plan to the Case Manager.

When the CM/SSS receives the written request and updated Negotiated Care Plan, the CM/SSS must:

* Review the request to determine if the changes meet the criteria of a Significant Change as defined in [WAC 388-76-10000](http://apps.leg.wa.gov/wac/default.aspx?cite=388-76-10000).
* If the request does not meet the criteria in WAC, document the reason(s) in a SER and notify the AFH provider.
* If the request is not complete or lacks sufficient detail to determine if a Significant Change Assessment is warranted, the SSS/CRM will contact the AFH provider and request additional information.
* The SSS/CRM will enter a Service Episode Record (SER) when the request is received and for each interaction with the provider to obtain the information needed.
* When all required information has been received, the SSS/CRM will use the *AFH Sig Change Request* SER Purpose Code in CARE and enter the date the complete written request was received. (CARE will then generate a tickler to send reminders on the 20th and 27th calendar day from the written request date to complete the assessment and move it to current.)
* Complete the significant change assessment and move it to current no later than 30 calendar days from the date the complete written request was received.

If the assessment results in an increase to the daily rate and the 30-calendar day timeframe is exceeded, the AFH provider may request a review by the department. If the AFH provider requests a review, the

Field Services Administrator (FSA) or designee will:

* Review the assessment to determine if it was not completed within 30 calendar days due to department error, and
* If due to department error, instruct the CM/SSS to authorize the increase to the daily rate starting on the 31st calendar day from the date of the *complete* written request.
* Keep a record of the number of reviews completed and the results of each review.

### Authorization of Services

Prior to authorizing payment for any long-term service or support, the following must be completed:

1. Program Eligibility - the CM/SSS has determined financial eligibility and functional program eligibility as determined by a *Current* CARE assessment
2. The client has chosen the program/services from which they are eligible:
   * All services (paid through ALTSA or not) must be indicated on the plan of care
   * Do not delay implementation of other identified services for which the client is eligible as indicated by their Current assessment, if a personal care provider has not yet been identified. For example, community transition items may need to be purchased or the authorization of a Community Choice Guide (CCG) to assist with hiring a caregiver
3. The client has approved the plan of care and given consent for services
4. The client has chosen a qualified [provider(s)](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0040)
5. Qualified provider(s) are selected from the ProviderOne database in CARE > *Supports* screen
6. Tasks are assigned to qualified provider(s) in CARE > *Supports* screen; and
7. Verification of any client responsibility and/or room & board
8. Complete all authorizations in CARE. See [Social Service Authorization Manual (SSAM)](https://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/SSAM/SSAM.html) for detailed instructions on authorization of services.
9. Complete electronic form [DSHS 14-443](https://www.dshs.wa.gov/sites/default/files/forms/pdf/14-443.pdf) in Barcode. A 14-443 should only be sent for a MAGI client when they need to be transitioned to S02 and are losing MAGI coverage.

Payment for most services cannot occur while the client is an institutional setting (hospital, nursing facility or jail). State-only exceptions may exist. See policy chapter for specific service in question.

Payment authorizations for personal care services must be adjusted or ended during the time client is in an institutional setting.

#### When do I transfer the case?

Transfer the active case to the appropriate AAA office or HCS residential SSS when the assessment has been moved to *Current*, have confirmed that services are in place, and you have a signed/dated Service Summary returned from the client. Refer to Transfer Protocol in [Chapter 5](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205.docx).

***When do I move an assessment to Current?***

Move the assessment to *Current* status:

* After the client has provided verbal plan approval (consented) to the services identified in the assessment and plan of care; and
* Prior to sending a Planned Action Notice for services.

***When do I move an assessment to History?***

* The assessment will automatically be moved to *History* once a newly created/pending assessment is moved to *Current*.
* You may manually move an assessment into *History:*
  + When the client is no longer receiving services due to ineligibility;
  + When the client declined services;
  + Before sending the Planned Action Notice, if the client has requested an Administrative Hearing, after being found functionally ineligible; or
  + When a *Pending* assessment has been created and is no longer valid or cannot be completed, due to reasons such as the client moves out of state, declines assessment, etc. Document the reason in *Reason for assessment on the Assessment Main screen* and/or via a SER note.

### Exception to Rule (ETR) Process

Before authorizing any exceptions to rule (ETR), you will need to get local or headquarters (HQ) approval, depending on the type of request.

#### Local ETRs

The local, regional/AAA level must review and render decisions for the following ETR requests where services/rate exceeds program limits *before* they can be authorized:

* The maximum allowed for environmental modifications;
* The maximum allowed for specialized medical equipment and supplies;
* The rate for COPES transportation services;
* The maximum units allowed for COPES client training;
* The maximum units allowed for Community Choice Guide (CCG);
* The maximum allowed for COPES Community Support: Goods and Services;
* The maximum allowed for Community Transition and Sustainability Service (CTSS); or
* Requests to exceed Residential Social Leave.

**For HCS/AAA**: At a minimum, a Field Approver must render a decision on a local ETR request. Field Review is optional based on local agency policy.

#### HQ ETRs

HQ must review and render decisions for the following ETR requests before they can be authorized:

* Any requests to authorize personal care services beyond the maximum hours/budget/daily rate generated by CARE. A new request must be submitted for each subsequent Annual, Significant Change or Initial Re/Apply assessment.
* Any request to authorize a combination of personal care, home-delivered meals (including Older American’s Act), and/or Adult Day Care services beyond the maximum number of hours or daily rate generated by CARE.
* COPES skilled nursing services requests. See [Chapter 7d](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207d.docx) for information about when an ETR is required.
* MPC, RSW or CFC requests to utilize MCO funding for Wraparound Support services that exceed the maximum hours/daily rate generated by CARE.
* All requests related to CHORE such as requests to pay a spouse provider an amount in excess of Medical Care Services (MCS), requests to exceed program maximum hours/month of 116, and requests to remain on the program in order to keep spouse provider when client becomes financially eligible for MPC or CFC.
* PDN requests that exceed 16 hours/day of PDN services.
* PDN requests to authorize PDN and in-home personal care that, in total, exceed the maximum hours generated by CARE.
* CFC Community Transition Services (CTS) requests that exceed the limit.
* CFC Assistive Technology (AT) and/or Skills Acquisition Training (SAT) purchases/services in excess of the CFC state fiscal year (SFY) annual limit.
* All bathroom equipment authorized using SA875 (excludes urinals, transfer poles and handheld showers which are authorized using SA421). See *Bathroom Equipment ETR training* found [here](http://intra.altsa.dshs.wa.gov/training/DME/).
* Lift Chairs when furniture portion exceeds rate maximum of $1800 (typically necessary solely for double or triple width chairs). See [*Service Code Data Sheet*](https://intra.dda.dshs.wa.gov/ddd/p1servicecodes/) for [SA419](https://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/Service%20Codes/SA419_Furniture_portion_of_lift_chair.docx) for more information.
* Durable Medical Equipment (DME) for the following situations:
  + An item is covered by insurance, but the client does not meet the medical criteria for the item to be paid for by insurance (example: client *needs* a heavy-duty hospital bed to live successfully in a community setting but does not meet the weight criteria for coverage by medical insurance).
  + The item is never covered by insurance, but it may be *necessary* for a client to live successfully in the community [example: fully electric bed is *needed (*not just for convenience), but insurance only covers a semi-electric bed].

**Personal care ETRs are always attached to a specific assessment.** When an assessment is moved to history, any attached ETR automatically moves to history; however, Interim assessments do not move an ETR to history. The ETR will attach itself to the new Interim assessment. If the Interim assessment did not result in a change in classification, in-home hours, or residential rate, you may rely on the current ETR until its end date. If the Interim assessment changed the classification, in-home hours, or residential daily rate, then it must be resubmitted to HQ for review.

#### Who can request a personal care ETR?

A client may request an ETR or a CM/SSS/CRM may request an ETR on the client’s behalf. After a review by the local office, the ETR committee at HQ makes the final decision and takes into consideration the following:

1. The exception would not contradict a specific provision of federal law or state statute; and
2. The client's situation differs from the majority; and
3. It is in the interest of overall economy and the client's welfare; and either
   1. It increases opportunities for the client to function effectively; or
   2. A client has impairment or limitation that significantly interferes with the usual procedures required to determine eligibility and payment and/or the client is at serious risk of institutionalization.

#### In-Home Client Request

1. If a client requests additional in-home personal care hours/budget above the CARE generated amount, the CM/SSS/CRM must have a conversation with the client and/or client representative to discuss the request and to identify how the frequency and duration of the assistance with personal care tasks differs from the majority. CM/SSS/CRM will use their professional judgment to determine if an ETR is appropriate or provide case management services to see if other options are more appropriate (e.g., using split shifts to maximize coverage when appropriate, informal supports, or other waiver and/or CFC options such as Home Delivered Meals, Adult Day Health, Adult Day Care, PERS, Assistive Technology, etc.)
2. If the client’s initial request for an ETR is denied at the field level either verbally by the CM/SSS/CRM or in CARE by the Field Reviewer, a Notice of Decision on Request for an In-Home Personal Care Exception to Rule(DSHS Form 15-429) via CARE > *Notices* screen, must be sent to the client. Clients do not have administrative hearing rights for initial ETR request decisions. If the ETR request is denied at the field level the client may request a review by the HQ ETR committee. The client may ask for a review by contacting the CM/SSS/CRM or by writing the ETR committee directly. These instructions are indicated on the 15-429 form mailed to the client. CM/SSS/CRM will submit the requests for HQ review through CARE using the standard ETR Categories and Types and indicate the client’s request by checking the *Client requested ETR HQ review* checkbox. **Only use this checkbox if the initial request was denied locally and the client has requested a review by HQ**.
3. **If the client directly contacts the ETR committee at HQ requesting review of an initially denied ETR, the ETR Program Coordinator will**:

* Notify the field reviewer, field approver, or supervisor of the client’s assigned office of the request for review; and
* Forward any communication sent to the ETR committee by the client/client representative to the field office.

**The field office will:**

* Contact the client regarding the client’s request for review if the communication received by the client contains new or additional information that was not reported in the initial request.
* Submit a new ETR request to the HQ ETR Committee through CARE using the standard ETR Categories and Types, and indicate the client’s request by checking the *Client requested ETR HQ review* checkbox.

1. The HQ ETR committee will make an individualized determination to approve, partially approve or deny the ETR request based on [WAC 388-440-0001](https://app.leg.wa.gov/wac/default.aspx?cite=388-440-0001).

***What is the process for submitting an ETR request to the HQ ETR Committee?***

#### ETR Requests for in-home clients

1. **For In-Home Personal Care ETRs**

Create an ETR within CARE utilizing the appropriate Category and Type for all ETRs. See the ETR chart for types and approval authority. To complete the ETR request in CARE:

1. Use the *Date Range* dropdown to select either Plan Period or Custom. Use custom only for short-term or time specific requests.
2. Use the *Hours* field to indicate the number of ADDITIONAL hours requested above the CARE generated hours.
3. In the *Request Description* tab, note the CARE-generated personal care hours, the additional amount requested by the assessor or client, and the proposed schedule. Include any specific information about how personal care needs are addressed by formal and informal supports and any gaps in service you are proposing to address through the ETR request.
4. In the *Justification for Request* tab, list the clinical characteristics and outline the specific personal care tasks performed that support the request. This information should describe how the client’s situation differs from the majority.
5. In the *Alternatives Explored*tab, detail other options that have been attempted or explored (e.g., split shifts, community supports, waiver and/or CFC services, etc.)
6. Process for Field Review or Field Approval depending on local office policy. The ETR must have Field Approval before processing to HQ.
7. HQ will review and finalize Personal Care ETR requests within 7 business days of receipt.
8. HQ will review and finalize Personal Care ETR requests within 3 business days when the processing comments of the request indicate the client is awaiting discharge from an Acute Care Hospital.
9. Once the ETR decision has been finalized the primary CM will receive notification via a CARE tickler. The CM must review the ETR outcome decision to confirm whether the request was approved, partially approved, or denied and to confirm the begin/end dates of an approved ETR as the dates may be something other than “plan period”.

When an ETR request has been approved for the plan period, the ETR Committee Decision Date is always the effective date of the ETR and the effective date of the authorization of payment.

1. **For initial personal care ETR requests that are:**
2. **Approved/Partially Approved**, include the additional hours via CARE > *Care Plan* screen > *Personal care adjustments* > *HQ Approved Personal Care ETR*. This will result in the adjustment to total hours to print on the client’s Service Summary, to send to the client for signature. Authorize CARE generated benefit and approved ETR amount in the payment system (see *Authorizing Personal Care ETRs in CARE* section below).
3. **Approved/Partially Approved, or Denied**, send a Notice of Decision on Request for an In-Home Personal Care Exception to Rule(DSHS Form 15-429) via CARE > *Notices* screen, to the client. Clients do not have administrative hearing rights for initial ETR request decisions.
4. **For ETR requests that were approved in the previous plan period, or, are being requested to extend a custom date range:**
   1. **Approved/Partially Approved, denied, reduced, or terminated**, note any approved hours via CARE > *Care Plan* screen > *Personal care adjustments* > *HQ Approved Personal Care ETR*. This will result in the adjustment to total hours to print on the client’s Service Summary, to send to the client for signature.  Send a services PAN to the client indicating the approval, denial, or reduction in hours. The client has an administrative hearing right for ETRs authorized in the plan period that immediately precedes the new ETR request. Authorize CARE generated benefit and approved ETR amount in the payment system (see *Authorizing Personal Care ETRs in CARE* section below).

**Example:**

A client’s 2022 CARE assessment resulted in 158 hours of personal care. The CM submitted an ETR request for 100 additional hours and it was approved. The total number of hours approved and authorized in 2022 was 258 hours. This client’s 2023 CARE assessment also resulted in 158 hours, and the CM submitted an ETR request for 125 additional hours. If the ETR request is partially approved for 100 hours, the total number of hours for which the client is eligible is still 258. Send a services PAN for the 258 hours. Send a **Notice of Decision on Request for an In-Home Personal Care Exception to Rule** (in CARE > Notices screen**)** for the additional 25 hours that was requested but not approved.

1. **When a client’s total in-home personal care hours/budget including an ETR are reduced or terminated, send a PAN to the client.**

**Example:**

A client’s 2022 CARE assessment resulted in 158 hours of personal care. The CM submitted an ETR request for 100 additional hours and it was approved. The total number of hours approved and authorized in 2022 was 258 hours. This client’s 2023 CARE assessment resulted in 115 hours and the CM submitted an ETR request for 100 hours that was approved. The total number of hours for which the client is eligible is 215. Send a services PAN indicating a reduction from 258 hours to 215 hours.

1. If an ETR was approved and authorized in the plan period preceding a new request and the new ETR requests personal care hours/budget above the amount of the previous ETR request, the additional amount is considered an initial request. Based on the decision for the additional amount by the ETR committee, follow the policy above for initial requests.

#### ETR requests for residential clients

An Exception to Rule to the published daily rate of a residential setting may be appropriate in situations where a client may have exceptional needs that differ from the majority and meet additional criteria as described in [WAC 388-440-0001](https://apps.leg.wa.gov/wac/default.aspx?cite=388-440-0001). ETRs are reviewed and decided based upon individualized needs for assistance with personal care or skilled care, how those differ from the majority of clients in the same classification group, and any specific information provided by the Social Service Specialist and the provider.

**Except for specific rates bargained in the Collective Bargaining Agreement (CBA) and relevant Memorandums of Understanding (MOUs), there is no standard rate (hourly or daily) used in determining the amount of an ETR. Unless specific rates are called out in the CBA, do not communicate that there are standard methodologies or rates used in the ETR process as it conflicts with the intent of ETRs.**

The focus of conversations about whether a provider will admit a client should be based upon the needs of the client as documented in the assessment and plan of care. Similarly, any conversation around an ETR with a provider should focus on the personal care needs of the client and, how those needs differ from the majority.

ETR approvals are at the sole discretion of the department and are reviewed based upon the individualized circumstances presented. It is an expectation that when an ETR is submitted by an SSS/NCC that they understand and can articulate why the request is being made. If the SSS/NCC does not agree that an ETR is necessary, the request can and should be denied at the local level. AFH providers can request that an ETR be reviewed by the HQ ETR committee when it is not initiated by the local office.

Because AFHs are authorized using a daily rate, when an ETR is requested, the daily amount being requested must be identified. The ETR Committee will review, considering the individualized needs of each client, and make a final determination based on the assessment, plan of care, and the ETR documentation. The amount approved by the ETR Committee will be added to the CARE generated daily rate based on the conclusion that the client’s needs look different from the majority of others in the same classification group. Per WAC 388-76-10195, it is the responsibility of the AFH to ensure enough staff are available in the home to meet the needs of each resident. Unless required under a specialized contract, it is not the responsibility of HCS to determine staffing levels. The needs of the individual should be clearly documented in the assessment and plan of care.

**AFH provider notices about ETR requests:**

The Adult Family Home Council Collective Bargaining Agreement (CBA) requires the state to provide a written notice to an AFH provider whose current or referred client’s level of care is being considered through the ETR process during the initial discussion with an AFH provider.

Provider notices will only be sent electronically, and be in the form of postcards, which must be provided to the AFH provider(s) by field staff during initial discussion with an AFH provider of a potential ETR request for current or referred client.

**For residential personal care ETRs:**

1. Use the *Date Range* dropdown to select either Plan Period or Custom. Use custom only for short-term or time specific requests.
2. Use the *Rate* field to indicate the ADDITIONAL rate requested above the CARE generated rate.
3. In the *Request Description* tab, note the CARE Classification and daily rate generated by CARE (including any add-on outside of CARE e.g., SBS or ECS) and the additional amount requested by the assessor.
4. In the *Justification for Request* tab, list the clinical characteristics and outline the specific personal care tasks performed that support the request. This information should describe how the client’s situation differs from the majority.
5. In the *Alternatives Explored* tab, detail other options that have been attempted or explored (e.g. assistive devices that have been considered or utilized, community and behavior supports, waiver and CFC services, etc.).
6. Process for Field Review or Field Approval depending on local office policy.  The ETR must have Field Approval before processing to HQ.
7. HQ will review and finalize residential personal care ETR requests within 7 business days of receipt.
8. HQ will review and finalize Personal Care ETR requests within 3 business days when the processing comments of the request indicate the client is awaiting discharge from an Acute Care Hospital.
9. Once the ETR has been finalized, the primary CM will receive notification via the CARE tickler. It is important to review the ETR outcome decision to confirm if the request was approved, partially approved, or denied, and to confirm the start/end dates of the approved ETR, as they may be something other than “plan period.”
10. **For initial residential personal care ETR requests that are:**
    1. **Approved/Partially Approved**, note the additional rate on the Service Summary, initial and date, and send to the client for signature. Authorize CARE generated benefit and approved ETR amount in the payment system (see *Authorizing Personal Care ETRs in CARE* section below).
11. **Initiated, Not initiated,** **Approved, or Denied**, send a Notice of Action Exception to Rule (CARE > Notices screen) to the client. For Adult Family Home requests, use Notice of Action Exception to Rule for AFH Daily Rates (CARE > Notices screen), and send a copy of this completed form to the client and the AFH provider. For all other residential settings, (e.g., Assisted Living, Adult Residential Facility, etc.) use Notice of Action Exception to Rule (excluding AFH, via the CARE > Notices screen). If the ETR is approved or partially approved, include, and confirm in CARE, the approved time period. The start date must not be prior to the HQ ETR Committee decision date. The end date cannot exceed the end date of the plan period. Clients do not have administrative hearing rights for initial ETR request decisions.
12. **For residential ETR requests that were approved in the previous plan period or are being requested to extend a custom date range:**
13. **Approved/Partially approved, reduced, or terminated,** note any approved rate on the Service Summary, initial and date, and send to the client for signature.  Send a services PAN to the client indicating the approval, denial, or reduction in rate. The client has an administrative hearing right for ETRs authorized in the plan that precede the new request. Authorize CARE generated benefit and approved ETR amount in the payment system (see *Authorizing Personal Care ETRs in CARE* section below).
14. If an ETR was approved and authorized in the plan period preceding a new request and the new ETR requests personal care rate above the amount of the previous ETR request, the additional amount is considered an initial request. Based on the decision for the additional amount by the ETR committee, follow the policy above for initial requests.

**NOTE for all in-home and residential personal CARE ETR decisions:** If an ETR request was approved/partially approved for hours/budget/rate and the CM makes a change that effects the classification or the hours/budget/rate, the CM must submit a new request if it is still warranted.

#### What notice to use for ETR requests and decisions

| **ETR Request Types**  **(including MCO)** | **Planned Action Notice Should Include:** | **-In-Home ONLY-**  **Notice of Decision for ETR (15-429)** | **-AFH ONLY -**  **Notice of Action ETR AFH (05-256)** | **-AL/ARC/EARC ONLY -**  **Notice of Action ETR (05-246)** |
| --- | --- | --- | --- | --- |
| **ETR rate/hours are requested for the first time**  *Client did not have this ETR in the preceding plan period.* | Only CARE generated rate/hours | Based on setting, use appropriate Notice of Decision/Action Form through CARE > Notices screen, to communicate the outcome of the initial ETR request. | | |
| **ETR continuation requested and approved**  *Client had the same ETR in the preceding plan period.* | Combine CARE generated rate/hours + ETR rate/hours | Do not use Notice of Decision/Action. | | |
| **ETR continuation AND an additional amount requested**  *Client had some of the ETR rate/hours in the proceeding plan period, but more is requested this time.* | CARE generated rate/hours + only ETR rate/hours that were approved in the preceding plan period | Based on setting, use appropriate Notice of Decision/Action Form through CARE > Notices screen, to communicate the outcome of the NEWLY requested amount. | | |
| **ETR continuation requested but denied**.  *Client had the same ETR rate/hours in the preceding plan period, but the request was denied this time.* | Communicate this information as part of the PAN whether the total rate/hours increased, decreased, or stayed the same. | Do not use Notice of Decision/Action. | | |

#### HCS/AAA Complaint Procedure

When a client does not have an administrative hearing right on an initial ETR decision, they have the right to make a complaint to the Department. Complaints related to initial ETR decisions made at the field level (e.g., COPES waiver services such as environmental modifications, specialized medical equipment, client training, etc.) will be reviewed as follows:

**For local Initial ETR decisions made by HCS:**

1. The client may make a complaint in writing to the Field Services Administrator (FSA). The FSA will make a decision about the complaint within ten days of the date it was received, send a letter informing the client of the decision, and that the decision may be reviewed by the Regional Administrator (RA) at the client’s request.
2. If the client makes a written request asking the RA to review the FSA’s decision, the RA will make a decision about the complaint within ten days of the date it was received and send a letter informing the client of the final decision.

**For local Initial ETR decisions made by AAA:**

1. The client may make a complaint in writing to the AAA Case Management Director/Program Manager. The AAA Case Management Director/Program Manager will make a decision about the complaint within ten days of the date it was received, send a letter informing the client of the decision, and that the decision may be reviewed by the AAA Director at the client’s request.
2. If the client makes a written request asking the AAA Director to review the Program Manager’s decision, the AAA Director will make a decision about the complaint within ten days of the date it was received and send a letter informing the client of the final decision.

**For Initial ETR decisions made by Headquarters:**

1. The client may make a complaint in writing to the HCS State Unit on Aging (SUA) Office Chief. The Office Chief will make a decision about the written complaint within ten days of the date it was received, send a letter informing the client of the decision, and that the decision may be reviewed by the HCS Director at the client’s request.
2. If the client makes a written request asking the HCS Director to review the Office Chief’s decision, the Director will make a decision about the complaint within ten days of the date it was received and send a letter informing the client of the final decision.

When responding to a complaint it is important to address, at a minimum, the specific concern perceived by the client and explain how all of information was reviewed (such as the CARE assessment, any additional information provided in the complaint, or information from other relevant sources) in order to make a decision. The CM/SSS may want to discuss the care plan with the client to identify service gaps that may be addressed using other available resources. ***If you must respond to a complaint that relates to an initial denial of a personal care ETR, please consult with the HCS CARE Program Manager.***

#### Authorizing Personal Care ETRs in CARE

**When an ETR is approved for the Plan Period:**

Authorize the total amount (CARE-generated hours/rate generated + the approved ETR amount) on one service line.

1. Authorization start date: the begin date on the authorization service line must match the ETR Committee Decision Date. ETR approvals cannot be backdated. The authorization start date must never be prior to the ETR Committee Decision Date.
2. Authorization end date: the end date on the authorization service line must match the plan period end date, via CARE Assessment Main Screen > Plan Period > End Date.

**When an ETR is approved for a custom date range:**

Authorize the total amount (CARE-generated hours/rate generated + the approved ETR amount) on one service line.

1. Authorization start date: the begin date on the authorization service line must match the Custom Start Date on the ETR screen entered by the ETR Committee. ETR approvals cannot be backdated. The authorization start date must never be prior to the ETR Committee Decision Date.
2. Authorization end date: the end date on the service line must match the Custom End Date in the ETR decision screen. **You may not extend the end date without approval of a new ETR request by the ETR Committee at Headquarters.**

**When the MCO funds an exceptional rate for a residential client:**

Authorize the CARE generated rate (and any capital add-on) on one service line, any SBS or ECS add-on rates on another service line, and the additional wraparound support rate on a separate service line using service code [SA389-U1](https://intra.dda.dshs.wa.gov/ddd/P1ServiceCodes/documents/Service%20Codes/SA389_U1_MCO_Funded_Behavioral_Health_Wrap_around_Support_Residential.docx). See LTC [Chapter 22a, *Apple Health Managed Care and Apple Health Medicare Connect (D-SNP)*](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2022a.docx)*,* for more information and instructions for MCO-funded BHPC Wraparound Support Services.

### Termination of Services

Terminate services when:

* The client is no longer financially eligible.
* The client is no longer functionally eligible based on their CARE assessment.
* A client chooses to decline *all* services for which they are eligible. Consider that many clients have other services in addition to personal care.
* The *Challenging Cases Protocol* (see [Chapter 5](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205.docx)) has been exhausted.
* The client is deceased. When the client had been receiving services through MPC or was eligible through MAGI, send Condolence Termination Letter ([DSHS Form #07-099](https://forms.dshs.wa.lcl/)) to the client’s representative/estate.

Steps to take when a client no longer meets program eligibility:

* Termination Planning (See [Chapter 5](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205.docx) > *Goals / Functions* section)
* A Planned Action Notice (in CARE) is required anytime there is an approval, increase, denial, reduction, or termination of a service (see [Chapter 5](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%205.docx)).
* Notify the Public Benefits Specialist (PBS) of a client’s ineligibility using form [14-443](https://www.dshs.wa.gov/sites/default/files/forms/word/14-443.docx) in Barcode (except for MAGI clients whose cases are not handled by PBSs). The PBS will determine Medicaid financial eligibility for other programs.

**Note:** MPC and CFC clients receiving SSI would continue to receive a Medicaid Services Card for Apple Health regardless of the receipt of personal care services.

## Resources

### Related WACs and RCWs

|  |  |
| --- | --- |
| [42 CFR 441.540(b)(9)](https://www.law.cornell.edu/cfr/text/42/441.540) | Person-centered Service Plan |
| [RCW 7.70.065](https://app.leg.wa.gov/RCW/default.aspx?cite=7.70.065) | Informed consent—Persons authorized to provide for patients who are not competent |
| [RCW 74.39A.525](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/) | Overtime Criteria |
| [RCW 74.39.050](https://app.leg.wa.gov/RCW/default.aspx?cite=74.39.050) | Individuals with functional disabilities-Self-directed Care |
| [WAC 388-106-0010](http://apps.leg.wa.gov/wac/default.aspx?cite=388-106-0010) | What definitions apply to this chapter? |
| [WAC 388-106-0050](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0050) | What is an assessment? |
| [WAC 388-106-0055](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0055) | What is the purpose of an assessment? |
| [WAC 388-106-0060](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0060) | Who must perform the assessment? |
| [WAC 388-106-0065](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0065) | What is the process for conducting an assessment? |
| [WAC 388-106-0070](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0070) | Will I be assessed in CARE? |
| [WAC 388-106-0075](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0075) | How is my need for personal care services assessed in CARE? |
| [WAC 388-106-0080 to 0145](https://apps.leg.wa.gov/wac/default.aspx?cite=388-106-0010) | CARE Classifications |
| [WAC 388-472-0020](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-472-0020) | How does the department decide if I am eligible for NSA services? |
| [WAC 388-71-05640](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-71-05640) | Self-directed care — Who must direct self-directed care? |
| [WAC 388-440](https://app.leg.wa.gov/WAC/default.aspx?cite=388-440) | Exception to Rule |
| [WAC 388-71-05640](https://apps.leg.wa.gov/wac/default.aspx?cite=388-71-05640) | Self-Directed Care |
| [WAC 388-472-0020](https://apps.leg.wa.gov/WAC/default.aspx?cite=388-472-0020) | Necessary Supplemental Accommodations |

### Acronyms

A complete list of WA. State DSHS acronyms can be found [here](https://www.dshs.wa.gov/sesa/office-communications/acronyms).

|  |  |
| --- | --- |
| AAA Area Agency on Aging | IADL Instrumental Activities of Daily Living |
| ACP Address Confidentiality Program | IP Individual Provider |
| ACRS Asian Counseling and Referral Service | LEP Limited English Proficient |
| ADA Americans with Disabilities Act | LTSS Long-Term Services and Supports |
| ADL Activities of daily living | MCO Managed Care Organization |
| AFH Adult Family Home | MMSE Mini-Mental State Examination |
| AH Apple Health (Medicaid) | MPC Medicaid Personal Care |
| ALF Assisted Living Facility | NCC Nurse Care Consultant |
| ALTSA Aging and Long-Term Support Administration | NFLOC Nursing Facility Level of Care |
| APS Adult Protective Services | NGMA Non-Grant Medical Assistance |
| ARC Adult Residential Care | NSA Necessary Supplemental Accommodations |
| AREP Authorized Representative | NSA/CP Negotiated Service Agreement/ Care Plan |
| AT Assistive Technology | OAA Older American's Act |
| CARE Comprehensive Assessment Reporting Evaluation | P1 ProviderOne |
| CCG Community Choice Guide | PAN Planned Action Notice |
| CDE Consumer Directed Employer | PBS Public Benefits Specialist |
| CFC Community First Choice | PCRC Personal Care Results Comparison |
| CFR Code of Federal Regulation | PCR Personal Care Results |
| CISC Chinese Information and Service Center | PDN Private Duty Nursing |
| CM Case manager | PERS Personal Emergency Response Systems |
| CMS Centers for Medicare and Medicaid Services | QA Quality Assurance |
| COPES Community Options Program Entry System | RA Regional Administrator |
| CRM Case Resource Manager (DDA) | RCL Roads to Community Living |
| CTS Community Transition Services | RCW Revised Code of Washington |
| DDA Developmental Disability Administration | RSW Residential Support Waiver |
| DES Department of Enterprise Services | SAT Skills Acquisition Training |
| DME Durable Medical Equipment | SBS Specialized Behavior Support |
| DMS Document Management System | SCSA Senior Citizens Services Act |
| D/POA Durable/Power of Attorney | SDC Self-directed Care |
| DSHS Department of Social and Health Services | SER Service Episode Record |
| EARC Enhanced Adult Residential Care | SES Specialized Equipment and Supplies |
| ECR Electronic Case Record | SNF Skilled Nursing Facility |
| ECS Expanded Community Services | SOP Skin Observation Protocol |
| ESA Economic Services Administration | SS Social Services |
| ESF Enhanced Services Facility | SSAM Social Service Authorization Manual |
| ETR Exception to Rule | SSN Social Security Number |
| FSA Field Services Administrator | SSS Social service specialist |
| HCA Health Care Authority | VDC Veteran’s Directed Care |
| HCS Home and Community Services | WAC Washington Administrative Code |
| HIU HCS Imaging Unit | WWL Work Week Limit |
| HQ Headquarters |  |

## Revision History

| **Date** | **Made By** | **Change(s)** | **MB #** |
| --- | --- | --- | --- |
| 6/2020 | Debbie Blackner | Added additional situations when an HQ ETR is required (bathroom equipment, lift chair that exceeds furniture maximum and when specific DME scenarios). |  |
| 6/2020 | Debbie Blackner | Added COPES services CCG and Community Supports: Goods and Services to the Minimum Standards table |  |
| 6/2020 | Debbie Blackner | Bed rail policy added |  |
| 6/2020 | Rachelle Ames | Updated Case File Standards to include:   * updated list of documents to be scanned to the ECR * removal of language related to paper files * update translated documents section to be consistent with Chapter 15 |  |
| 6/2020 | Rachelle Ames | Updated Timeframes table included in the “Adding a Client to CARE” section |  |
| 12/2020 | Rachelle Ames | Removed incorrect RCW reference from “What to do when a client cannot sign” section |  |
| 12/2020 | Rachelle Ames | Updated Minimum Standards “Supports screen” section to reflect current CARE functionality |  |
| 12/2020 | Rachelle Ames | Removed “BHO” from MCO references to accurately reflect current terminology |  |
| 12/2020 | Rachelle Ames | Updated “Forms/Brochures” table with updated DSHS 14-225 form instructions | [H21-013](http://intra.altsa.dshs.wa.gov/docufind/MB/HCS/HCSMB2021/H21-013%20DSHS%20form%2014-225%20Revision%202021.docx) |
| 1/2021 | Rachelle Ames | Updated procedure related to ETRs and Interim assessments to be consistent with updated CARE functionality |  |
| 1/2021 | Rachelle Ames | Added clarification about consent form and who to contact with questions about privacy |  |
| 1/2021 | Rachelle Ames | Updated “What notice to use…” in ETR Section |  |
| 3/2021 | Rachelle Ames | Eliminated policy to assess shared benefit and added policy to include IP Informal Support Attestation | [H21-002](http://intra.altsa.dshs.wa.gov/docufind/MB/HCS/HCSMB2021/H21-002%20Amended%20SEIU%20775%20v.%20DSHS%20Lawsuit%20Settlement%20Agreement-Elimination%20of%20Shared%20Benefit.docx) |
| 9/2021 | Rachelle Ames | Updated Minimum Standards table related to emergency plan to be consistent with CARE Web |  |
| 9/2021 | Rachelle Ames | Added ETR FAQ Document attachments developed as part of an HCS statewide workgroup |  |
| 9/2021 | Rachelle Ames | Added 72-hour ETR turnaround timeframe when client is in an acute care hospital |  |
| 9/2021 | Rachelle Ames | Updated link to SDC publication |  |
| 9/2021 | Rachelle Ames | Updated reference to 14-443 and MAGI clients when the client is no longer MAGI |  |
| 9/2021 | Rachelle Ames | Updated ETR Approval/Authority table to current field practice |  |
| 9/2021 | Rachelle Ames | Updated how to document potential risk in the plan of care with updated CARE Web screen locations |  |
| 9/2021 | Rachelle Ames | Clarified decision-making authority in “Getting Approval on the Plan of Care” section |  |
| 9/2021 | Rachelle Ames | Updated Significant Change Request by an AFH section | [H21-061](http://intra.altsa.dshs.wa.gov/docufind/MB/HCS/HCSMB2021/H21-061%202021-2023%20CBA%20between%20the%20State%20of%20Washington%20and%20the%20AFHC.docx) |
| 12/2021 | Rachelle Ames | Updated “Brief” assessment type to “VDC” assessment type | [H21-087](http://intra.altsa.dshs.wa.gov/docufind/MB/HCS/HCSMB2021/H21-087%20CARE%20Change%20Control%20Information%20for%20the%2010-29-2021%20Release.docx) [H21-047](http://intra.altsa.dshs.wa.gov/docufind/MB/HCS/HCSMB2021/H21-047%20CARE%20Change%20Control%20Information%20for%20the%206-30-2021%20Release.docx) |
| 12/2021 | Rachelle Ames | Clarified “When to inactive a client record in CARE” section |  |
| 12/2021 | Victoria Nuesca | Added updated “Care Planning Advocate” flow chart to “Attachments” section | [H15-054](file:///C:\Users\NuescVL\Downloads\H15-054%20Service%20Plan%20Signatures%20and%20Client%20Representatives.doc) |
| 6/2022 | Rachelle Ames | Edits related to IPs becoming employed by the CDE | [H21-083](https://intra.altsa.dshs.wa.gov/docufind/MB/HCS/HCSMB2021/H21-083%20Amended%20CDE%20Policy%20and%20Procedure%20changes%20Post%20CDE%20Implementation%205.13.22.docx) [H22-027](https://intra.altsa.dshs.wa.gov/docufind/MB/HCS/HCSMB2022/H22-027%20CDWA%20Client%20IP%20Referral.docx) |
| 9/2022 | Victoria Nuesca | Updated language from provider to “caregiver” to not exclude IPs hired by CDWA | [H15-054](file:///C:\Users\NuescVL\Downloads\H15-054%20Service%20Plan%20Signatures%20and%20Client%20Representatives.doc) |
| 9/2022 | Rachelle Ames | Addition of Voice Signature option and Script Attachment |  |
| 5/2023 | Dru Aubert | * Updated how to document the number of monthly hours the client is choosing not to utilize, and adjustments for waiver services and/or HQ approved personal care ETRs. * Updated the AAA CM or nurse completes VDC assessment types for participants in the VDC program. | [H22-046](https://intra.altsa.dshs.wa.gov/docufind/MB/HCS/HCSMB2022/H22-046%20CARE%20Change%20Control%20Information%20for%20the%209-30-2022%20Release.docx) |
| 8/2023 | Dru Aubert | * Updated Voice Signature attachment>FAQs in “Appendix” section. * Added timeframe Service Summary signatures must be obtained. * Updated “ETR requests for residential clients” section. * Added when to include the IP Informal Support Attestation form under “Special Considerations” section. | [H21-002](https://fortress.wa.gov/dshs/adsaapps/Professional/MB/HCSMB2021/h21-002%20amended%20seiu%20775%20v.%20dshs%20lawsuit%20settlement%20agreement-elimination%20of%20shared%20benefit%2006.06.24.docx) |
| 12/2023 | Dru Aubert | * Removed PACE from LTSS ETR Types and Approval Authority section. * Added assessment policy update to assess Adult Day Care (ADC) as Informal Support ([WAC 388-106-0010](https://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0010)). * Updated Voice Signature attachment>FAQs in “Appendix” section, related to HIU submission. * Specified DSHS contracted providers should be added to the written Consent Form (DDA-only). | [H23-078](https://fortress.wa.gov/dshs/adsaapps/Professional/MB/HCSMB2023/h23-078%20assessing%20adult%20day%20care%20as%20an%20informal%20support.docx) |
| 2/2024 | Dru Aubert | * Updated *Assessment Location Grid* to state hospital assessments need to be within 7 days from the date of referral. * Included Community Psychiatric Hospital Setting into *Timeframes* table * Updated Voice Signature attachment>FAQs in “Appendix” section. * Added combined *Notice of Consent of Communication via Text or Unencrypted Email* (DSHS Form 27-156). |  |
| 6/2024 | Dru Aubert | Eliminated policy to assess IP as a source of informal support ([SUBSTITUTE HOUSE BILL 1942)](https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/House/1942-S.SL.pdf?q=20240417152605) and retire DSHS Form 27-203 “Individual Provider (IP) Attestation of Informal Support”. | [H24-025](https://fortress.wa.gov/dshs/adsaapps/Professional/MB/HCSMB2024/h24-025%20discontinue%20assessing%20an%20ip%20to%20be%20a%20source%20of%20informal%20support.docx)  [H21-002](https://fortress.wa.gov/dshs/adsaapps/Professional/MB/HCSMB2021/h21-002%20amended%20seiu%20775%20v.%20dshs%20lawsuit%20settlement%20agreement-elimination%20of%20shared%20benefit%2006.06.24.docx)  *(amended 6/6/24)* |
| 7/2024 | Dru Aubert | * Updated “How and when do I distribute the plan of care to the provider(s)?” section to add hospital discharge planners (for those patients who are seeking Home and Community Based Services), Community Choice Guides, and Client Training Providers. * Clarified “More about signatures” section that a signature may be in any format that denotes the signatory agrees to the plan of care, including *typed*. * Removed duplicative “IP Overtime” section, that can be found in [Chapter 11](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2011.docx), Working with the Consumer Directed Employer. * Updated “Minimum Standards” section to describe the process and expectations of developing and completing a care plan, post assessment interview completion, to be used when transferring a case from one office to another. * Added to “Steps in performing a CARE Assessment” to include Community Behavioral Health Support (CBHS) Services/1915i (effective 7/2024). * Added ‘Individuals on Hospice’ to priority list of assessment eligibility. |  |

## Appendix

### Bed Rail Policy

Bed rails (also called side rails or safety rails) are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of shapes and sizes. Full and half bed rails are covered by Apple Health (AH) with no prior authorization. Medicare does not pay for bed rails of any length.

One-quarter and one-eighth length bed rails are never covered by AH or Medicare. These are frequently referred to as mobility bars/rails, bed support handles, standing bars and bed canes. Some ¼ and ⅛ length bed rails were recalled in December 2021 (see [MB H22-010](https://fortress.wa.gov/dshs/adsaapps/Professional/MB/HCSMB2022/h22-010%20bed%20cane%20recall.docx)).

Although bed rails have potential benefits for some individuals, potential risks of bed rails include:

* Strangulation, suffocation, bodily injury or death because an individual is caught between rails or between the bed rails and the mattress.
* Skin bruising, cuts, and scrapes.
* A higher risk of serious injuries from falls because sometimes individuals fall while trying to climb over bed rails. When that happens, the individual is often more seriously injured than if the person had fallen out of a bed without rails.
* Feeling agitated, isolated or unnecessarily restricted because the bed rails prevent individuals from moving freely.
* Loss of the ability to independently perform routine activities such as going to the bathroom or retrieving something from a closet because the individual is prevented from getting out of bed.

The use of any type of bed rail poses a potential safety risk regardless of care setting. The best way to prevent trapping or harming clients is to refrain from using bed rails and to encourage the use of safer alternatives. Bed rails must not be used as a restraint.

Bed rails are sometimes requested by a client who receives long-term services and supports (LTSS). At times, a new or reapplying client already has and uses a bed rail. The Bed Rail Policy must be followed in its entirety (Steps 1-10) for bed rails of any length in each of the following scenarios:

* For all DSHS clients receiving paid services in a community residential setting, including when:
  1. The residential provider will supply the bed rail.
  2. When insurance will pay for the bed rail (such as Apple Health).
  3. If the client is admitting to a residential setting with bed rails they already have/use, unless a bed rail evaluation ([DSHS Form 13-906](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=13-906&title=)) is on file and there has not been a significant change in condition that impacts the client’s ability to safely use the bed rail.
* When a bed rail will be purchased through a social services (SS) authorization, regardless of client’s setting (residential or in-home).

A bed rail evaluation is recommended in all other situations, including when:

* Apple Health will pay for the bed rail for a client receiving LTSS in an in-home setting.
* The client has a completed bed rail evaluation ([DSHS Form 13-906](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=13-906&title=)) in their electronic case record or file, but there has been a significant change in cognitive or physical condition that may impact the client’s ability to safely use the bed rail.
* For new or reapplying in-home clients who already have and use a bed rail, unless a bed rail evaluation is on file and there has not been a significant change in condition that impacts the client’s ability to safely use the bed rail.
* At a minimum, Steps 1 and 2 below should be completed and documented in a SER or a Progress Note in GetCare (MAC/TSOA).

**Requests for New or Replacement Bed Rail of Any Length (including if an item has been recalled)**

1. Providethe clienta copy of the FDA brochure *“*[*A Guide to Bed Safety*](http://www.fda.gov/downloads/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/HospitalBeds/ucm125857.pdf)*”.* The brochure is focused on institutional settings, but the information applies to any home and community-based setting.
2. Discusswith the client, their representative (if applicable) and providers:
   1. The risks of entrapment, injury and death from bed rails per *“*[*A Guide to Bed Safety*](http://www.fda.gov/downloads/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/HospitalBeds/ucm125857.pdf).”
   2. Explain to the client and/or representative that there are alternatives to bed rails and that a specialist can help the client determine what alternatives are best through an individualized evaluation. Alternatives may include roll guards, foam bumpers, low beds, a trapeze or standing transfer poles. Other alternatives may be recommended as part of the evaluation.
   3. Document the date the bed rail discussion occurred with the client and representative (if applicable) and the requirement for the individualized bed rail evaluation in a SER in CARE or a Progress Note in GetCare.
   4. The client can choose not to participate in the evaluation; however, without a completed evaluation:
      1. A bed rail cannot be used in a residential setting for a DSHS LTSS.
      2. A SS authorization cannot be used to purchase a bed rail, regardless of size or service code used: SA878 (full or half-length bed rail) or SA421 (¼ or ⅛ length rails).
3. The client requests a referral from their primary care provider (PCP) for a bed rail evaluation from a physical therapist (PT) or occupational therapist (OT):
   1. The bed rail assessment is paid for by the client’s AH medical plan. COPES Client Training cannot be authorized for this evaluation. Exception: if the client’s item has been recalled and there is an emergent need.
   2. The client must be referred to a PT or OT that is in their AH provider network (managed care) or a provider with a Core Provide Agreement (fee for service).
   3. The therapist may be employed or contracted by agencies such as home health or outpatient therapy clinics. For a client transitioning from a skilled nursing facility, this could be a SNF therapist.
   4. Following established procedures, the therapist requests an expedited prior authorization (EPA) from the client’s AH plan prior to completing the assessment.
   5. Step 3 is not necessary if:
      * 1. A SNF therapist will complete the assessment.
        2. If the evaluation will be performed in conjunction with another task the provider is authorized to complete and the provider will not claim the AH procedure code for bed rail assessment (97165/modifier: GO).
4. The SSS/CM requests the therapist’s contact information from either the PCP or client.
5. The SSS/CM completes Section 1 of [DSHS form 13-906](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=13-906&title=) and emails it to the therapist who will perform the assessment (note: Please make sure to use the most updated version).
6. The PT or OT:
   1. Completes the evaluation using generally accepted standards of practice and documents their recommendation(s) regarding the safe use of bed rails or alternative devices in Sections 2 and 3 on [DSHS form 13-906](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=13-906&title=) provided by the SSS/CM.
   2. Returns the completed form to the SSS/CM and sends a copy to the client’s primary healthcare provider.
   3. If unsure the intent of the bed rail recommendation, the case worker should clarify the results with the OT/PT.
7. The CARE SSS/CM:
   1. Documents the results of the evaluation in the “Comments” section on the *Bed Mobility* screen.
   2. Discusses the results with the client, provider, and representative (if applicable).
   3. Provides the residential provider a copy of the form (if applicable).
   4. Submits the completed form with a Packet Cover Sheet - Social Services ([DSHS Form 02-615](https://www.dshs.wa.gov/office-of-the-secretary/forms)) to HIU via Hotmail.
8. The GetCare SSS/CM:
9. If unsure the intent of the bed rail recommendation, the SSS/CM should clarify the results with the OT/PT.
10. Discusses the results with the client and provider(s).
11. Documents the results of the evaluation and the discussion with the client and provider(s) in a Progress Note.
12. Uploads the completed [DSHS Form 13-906](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=13-906&title=) into the client/care receiver’s electronic file cabinet in GetCare.
13. Based on the results of the evaluation documented in the completed [DSHS Form 13-906](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=13-906&title=), and the informed decision by client and/or representative, complete one of the steps below.
    1. **Recommendation is an alternative device:** depending on the item, follow all established procedures for either AH durable medical equipment (DME) or specialized equipment and supplies (SES) to assistthe client with obtaining the recommended item(s).
    2. **Recommendation is full or half-length bed rail(s):** client/vendor follows established AH DME procedures (with SSS/CM assisting, as necessary). Note:
14. AH pays for one pair of full or half bed rails every 10 years *with no prior authorization*. The client provides a prescription from their healthcare provider to a DME provider who will dispense the bed rail.
15. If a client has damaged their full or half bed rails or they have been lost before the 10-year limit has expired, the DME vendor should request a limitation extension (LE) from the client’s AH plan.
16. If the LE is denied and the client is enrolled in a LTSS program that includes DME, a SS authorization can be created in *Reviewing* status using blanket code **SA878**. Upon confirmation the client has received the item, the authorization is changed to *Approved* status and the DME vendor will be able to claim using the product’s HCPCS in the SS medical portal in ProviderOne.
    1. **Recommendation is one-fourth or one-eight length bed rail (also known as bed canes, mobility bars/rails, bed support handles, standing bars, and many other names):** a SS authorization is appropriate if client desires to use the item and the client is enrolled in a program that includes SES.

**Best Practice:** Utilize a *DME* vendor with the SES contract to authorize ¼ or ⅛ length bed rails. When requesting the quote, verify the item has not been recalled and that it meets the ASTM standard for adult portable bed rails.

Create the authorization in Reviewing status using **SA421** after completing all other steps. Upon confirmation the client has received the item, the authorization is changed to Approved status and the DME vendor will be able to claim in the SS portal.

* 1. **Use of a bed rail is NOT recommended** due to concerns about the client’s ability to safely use it:
  2. If the client resides in (or is transitioning to) a residential setting, the client will not be able to use a bed rail, per policy. Alternative devices or equipment can be requested by the client, if recommended in the evaluation.
  3. If the client resides in (or is transitioning to) an in-home setting:
* If the bed rail is being paid for by the client’s AH plan and the client/representative is making an informed decision based on the results of the evaluation, the client can request a prescription for a bed rail from the PCP and follow up with a DME vendor. Document informed decision in a CARE SER or GetCare Progress Note.
* A SS authorization cannot be used to purchase a bed rail, regardless of length.

1. If a client is not enrolled in Apple Health:
   1. For clients enrolled in TSOA: if client’s private insurance does not pay for the evaluation, TSOA funds can be used to pay for it.
   2. If a full or half-length bed rail is recommended following the evaluation, a SS authorization can be created in *Reviewing* status using blanket code **SA878**. Upon confirmation the client has received the item, the authorization is changed to *Approved* status and the DME vendor will be able to claim using the product’s HCPCS in the SS medical portal in P1.
   3. If a one-fourth or one eighth length bed rail is recommended (also known as bed cane, mobility bar/rail, bed support handle, standing bar, and many other names), follow all instructions in 8.c. above.

### Self-Directed Care

An adult with a functional disability living in their own home can direct and supervise a paid personal care aide (Individual Provider) to help with health care tasks that they cannot do without assistance because of their disability. Examples of Self-Directed Care (SDC) tasks include help with medications, injections, bowel programs, bladder catheterization, and wound care. Self-Directed Care under [Chapter 74.39 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.39) must be directed by an adult client for whom the health-related tasks are provided. The adult client is responsible to train the Individual Provider in the health-related tasks which the client self-directs.

For potential self-directed care (SDC) cases, you may refer to the Self-Directed Care Checklist (below) as a reminder of things to consider when doing an assessment. At the conclusion of the assessment process and plan development, obtain the client’s signature of agreement to the plan.

#### Self-Directed Care Checklist

This checklist is not mandatory and does not need to be put in the client's file. The checklist is designed to help staff remember things they should consider in SDC cases and indicate what additional coordination is needed to assist the individual to self-direct their care.

|  |
| --- |
| **Remember to ask the individual (client) and yourself these questions when assessing or reassessing a case:** |
| 1. Does the individual live in their own home (e.g., a residence that does not require licensure)? Self-directed care can only happen in a private home. Self-directed care ([RCW 74.39.050)](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.39.050) does not apply to clients living in licensed facilities. |
| 1. Does the individual have an Individual Provider (IP) through the CDE under CFC, MPC, New Freedom or Chore programs? HCS/AAA/DDA clients who are presumed competent, receiving CFC, MPC or any waiver program, and live in a private, non-licensed home can legally self-direct an individual provider.  * An IP can be a family member. * The IP cannot perform health care tasks for anyone else, only the person who has hired them to perform those tasks. |
| 1. Does this individual have a functional disability that prevents them from performing a healthcare task for themselves? The individual must be over 18 years of age. The client could have a traumatic brain injury (TBI), mental health or developmental disability and self-direct as long as the disability does not prevent them from having the ability to explain the procedure and to supervise the IP. There are varying degrees of function with every disability. The healthcare practitioner who prescribed the treatment or medication has the responsibility to ascertain if the individual understands the treatment or medication administration and is able to follow through on the SDC task. |
| 1. Has the SSS/CM informed the individual of the SDC option at the time of Initial assessment and reassessment? The SDC publication should be given to clients who potentially could self-direct their care, no matter what setting they are in. |
| 1. Does the individual have a legal guardian? (Only guardianships of the person limit personal decision-making. Guardianships of the estate only limit financial decision-making.) The individual self-directing is presumed competent. The health care practitioner who prescribed the treatment has the responsibility to ascertain if the person understands the treatment and is able to follow through on the SDC task just as they would when a person without a disability goes to the doctor and is given a prescribed treatment. No additional verification is needed. |
| 1. Did the individual inform the prescribing health care practitioner of their intent to self-direct? Is the prescribing health care practitioner’s name, address and telephone number documented in the CARE assessment? |
| 1. Has the individual provided the SSS/CM with the source of the treatment order? The SSS/CM should document in the CARE assessment the source of the treatment information.   Examples are: directions from the client, prescription container/Rx script, written directions from the prescribing health care practitioner, protocols from a professional association or protocols from a rehabilitation facility or institution manual. An actual copy of the treatment order or written directions is not mandatory but may be helpful for more complicated health-related tasks. |
| 1. On the *Treatment* or *Medication Management* section of the Medical screen in CARE, has the SSS/CM documented SDC tasks and selected “Self-Directed Care (IP only)” as a Provider Type for the treatment listed on the Treatments section? |
| 1. Does the client want to self-direct any portions of her/his care? The law does not require the individual to self-direct their healthcare. **The law does not have a task list.** |

**The responsibility of the client (person with the disability) is to:**

* Inform the prescribing healthcare practitioner who ordered the treatment or medication of the intent to self-direct;
* Inform the SSS/CM;
* Inform and provide training to the IP for those SDC tasks and ensure the IP has a copy of the current Service Summary and Assessment Details;
* Possess the necessary knowledge and ability to train the IP to those tasks;
* Supervise the performance of the IP; and
* Ask for assistance in training, if necessary.

**The SSS/CM must:**

* Inform the client of the SDC option. Share the SDC publication with the client at the time of assessment and reassessment; and
* Coordinate with the client to identify the SDC tasks and who will perform them and then, document on the *Treatments* and *Medication Management* sections of the Medical screens in CARE; and
* Provide copies of the current Service Summary and Assessment Details to the client and the IP.

**Problem Solving:** If the SSS/CM feels that the manner in which the clientinstructs the tasks to be done is potentially harmful or if the assessment reveals that the client has cognitive issues, memory loss, disorientation, or impaired judgment and the client is requesting to self-direct, the SSS/CM will:

* Discuss the situation with the client.
* Consult with a nurse consultant and case management supervisor.
* Clearly document concerns in a SER.
* After obtaining a signed Consent Form ([DSHS 14-012](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=14-012&title=)) from the client, confer with the prescribing health care practitioner.
  + - If the prescribing health care practitioner agrees the tasks are being done in a harmful manner, the case manager will not authorize the SDC tasks to be done.
    - If the client refuses to give permission to consult with the prescribing health care practitioner and concerns remain, the SSS/CM must consult with their supervisor to determine whether to authorize SDC tasks. The supervisor will thoroughly review the case and determine whether SDC should be authorized.
* Outcomes of the discussion with the client, and any other actions taken by the SSS/CM and/or client, must be clearly documented in a SER.
* If SDC is not authorized, the SSS/CM must develop an alternative plan of care, offer it to the client and document this in a SER.
* If SDC is not authorized, the IP may still be paid to perform other ADLs and IADLs as long as they meet the other requirements to be an IP. The IP may refuse to do SDC tasks at any time. The law does not force the IP to do SDC tasks they are not comfortable doing.

### Necessary Supplemental Accommodations (NSA)

Clients who have a mental, neurological, physical, or sensory impairment or other problems that prevent them from getting program benefits in the same way as those who are not impaired are considered in need of necessary supplemental accommodation. (See [WAC 388-472-0020](http://www.leg.wa.gov/wac/index.cfm?fuseaction=Section&Section=388-472-0020))

#### Developing Necessary Supplemental Accommodations (NSA)

Discuss with clients any issues that would hinder their ability to access DSHS programs and services and determine if they require any necessary supplemental accommodation services to ensure that they can submit the necessary information to the Public Benefits Specialist (PBS) for an initial (or on-going) determination of eligibility for Medicaid. If the client requires or requests NSA:

1. Select “Yes” on the *Care Plan* screen that the client has a need for an “NSA”.
2. Identify any special needs the client may have which would impact their ability to complete the initial application for public assistance and any reviews for ongoing eligibility.
3. Identify the family member, significant other, or other individual who can be identified as the person the PBS can contact (may require Consent – [DSHS Form 14-012](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=14-012&title=)).
4. In the comment box labeled “NSA Description” on the *Care Plan* screen indicate how client’s need for an NSA will be met and by whom.
5. Assist clients who are unable to manage this issue independently if no NSA is identified.
6. Indicate and describe the NSA on the 14-443 sent to the PBS through Barcode.

**EXAMPLE:** The client has significant cognitive impairment and cannot be responsible for the application and eligibility review process. Her daughter, who is her DPOA, will be identified as the contact person for the financial application and eligibility process.

**EXAMPLE:** The client cannot read. All forms must be sent to the designated representative.

**EXAMPLE:** The client has a hearing impairment so staff should not contact the client by phone or would need to use the TTY system when appropriate.

#### Implementing the Necessary Supplemental Accommodation (NSA)

In addition to documenting NSA information on the *Care Plan* screen, you must:

1. Describe the needed special accommodations to the PBS on form [14-443](https://www.dshs.wa.gov/sites/default/files/forms/word/14-443.docx). Include the address of the person identified as the client’s representative.
2. Document in a SER that this information was added to the [14-443](https://www.dshs.wa.gov/sites/default/files/forms/word/14-443.docx) to the PBS via Barcode.
3. Add the identified NSA to the *Collateral Contacts* screen and select the Contact Role of “Personal NSA”;
4. If the client does not have anyone to assist them, indicate that the CM/SSS will need to arrange for, or provide assistance with, completing forms, obtaining needed information, explaining the department’s adverse actions, requesting fair hearings, and providing follow-up contact on missed appointments. CM/SSS may be notified by a PBS that the client needs further assistance with their Medicaid eligibility reviews to ensure that there is no interruption in Medicaid eligibility.

HCS/AAA case records must be identified if the client has specific needs (e.g., large size print for forms, hearing impairment, cognitive impairments, limited reading ability, etc.) that are in addition to the required accommodations that are already recognized in HCS policy. Although all ALTSA LTSS clients are treated as if they are NSA, only develop an NSA plan and mark the case “NSA” in CARE if the client has specific NSA needs.

## Minimum Standards

The intent of Minimum Standards is to describe the process and expectations of developing and completing a care plan, post assessment interview completion. Use the Minimum Standards when transferring a case from one office to another.

|  |  |
| --- | --- |
| **CLIENT STANDARDS** | |
| Interpreter required | Follow guidelines outlined in [Chapter 15A/B](https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual). |
| Residence History | When client changes residence, start a new line (+). Do not edit the old line as this prevents history from being built. Use the Multi-Client Residence tab for in-home clients when appropriate. |
| Residence Type | Select the appropriate Residence Type from the dropdown. If the client is living with others, use the *Collateral Contact* screen to document their name(s) and their relationship to the client. |
| Collateral Contacts | List all household members and anyone who has contact with the client.  When adding a new contact or removing an old contact from the collateral *Contacts* table, use “+ Add new contact” and “Delete selected contact” buttons. Do not use “Edit” elements of *Contact Details* to replace the information in the table. Backspace or delete should only be used to make a correction to a current contact record, not to change the contact to a new individual or organization.  **Emergency Contact:**  List the name and phone number of the person who should be contacted in case of an emergency, (i.e., temporary backup care, wildfire, power outage, etc.).  Collateral Contacts other than an in-home personal care provider and/or household member should be considered first.  **Informal support:**  List the name and phone number of the client’s informal support and select the Contact Role of “Informal Caregiver.” This may be a family member, a friend, neighbor, or community resource. If the informal support is a person, it is not required that they actually live with the client rather that they visit regularly, and are willing and able to respond to the needs that the client may have. This role must be assigned when status in ADL and IADL screens indicate met or partially met tasks.  **Substitute decision maker:**  When the client has a legal substitute decision maker, the assessor must not accept or seek the person’s decisions without a copy of the paperwork that confirms the legal relationship. When the client has only an informal decision maker, this arrangement can only continue as long as the client is capable of telling this person what they want. The assessor will need to confirm any decisions made by the informal decision maker with the client. A General Power of Attorney may only be used if the client is cognitively intact.  **Individual Provider(s):** as known, list first and last name of each known and intended (client chosen) Individual Provider (IP), and their relation to the client, when services are provided by the Consumer Direct Care of Washington (CDWA).  When determining familial relationships, these are individuals who are important to, and designated by the client and who need not be a relative ([RCW 70.127.010(4)).](https://app.leg.wa.gov/RCW/default.aspx?cite=70.127.010)  **Healthcare providers:**  List the name and phone number of the client’s primaryhealthcare provider and any other healthcare provider(s) who have a role in the client’s plan of care. If the client does not have a primary healthcare provider, make sure the client has an emergency contact. |
| Financial | Financial eligibility must be verified and active (i.e., not in pending status) for the functional program being authorized (including Fast Track). Financial eligibility verification must occur at least annually. Indicate the method of verification (ACES online, financial award letter, etc.) on the *Financial* screen. |
| **ASSESSMENT** | |
| Reason for Assessment | State the reason for this assessment, documenting the client's or referent’s perception of the problem. For reassessments, delete the old reason for assessment and enter the current reason/circumstances for the reassessment. |
| Source of information | The client must be the primary source of information unless they cannot participate because of mental or physical reasons. |
| Planned living arrangement | Select “Lives with paid provider” on the Assessment Main screen if the client and their paid provider live together. Select “Multi-client household” on the Assessment Main screen if there are other clients in the household. If both apply, select “Multi-client household.” |
| Adult Family Home (AFH) Evacuation Level | Select the Evacuation Level from the dropdown on the Assessment Main screen. All AFH plans of care and negotiated plans of care must identify the resident's level of evacuation capability (see [WAC 388-76-10870](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-76-10870)). |
| Medications | Include information about each prescribed medication, if available, with at least the route of administration |
| Diagnosis | Confirm the diagnosis with the client’s healthcare provider when inconsistencies are noted or the source of the information is not reliable. Document the source of the information.  Use *Functional Limitations*, indicators, and/or comment boxes to provide information regarding the client’s physical functioning. |
| Treatments | * Check the treatment definitions to ensure an accurate description of the client’s needs. * Identify all providers for each treatment. * Rehab/Restorative Training (walking, transfer, bed mobility, etc.) over the past 14 days. Before you can select these activities be sure that:   1. Measurable objectives and interventions are included in the therapist's care plan;   2. Caregivers are trained in techniques that promote client involvement;   3. Programs are periodically re-evaluated by a skilled professional. Document this in the SER or comment box;   4. Time spent on each program must be at least 15 minutes a day;   5. You document in the comment box that the plan has been viewed or a copy is in the file.  All criteria mentioned above must be met before “Walking” can be selected.  This item does not include a recommendation by a healthcare provider that the client walk on a regular basis. |
| Self-directed care | Document self-directed care (SDC) tasks on the screen in which the task is addressed. Typically, these will be documented on the *Treatments* section on the Medical screen using “Self-Directed Care/IP only” as the provider type or on the *Medication Management* section (Administration of Medications).  Include the name of the healthcare provider prescribing the task as well as a description of the task being self-directed in the applicable comment box(es). Identify the SDC provider and schedule on the *Supports* screen. |
| Behavior | A current behavior must be addressed with a current intervention(s), provide individualized caregiver instructions (person-centered to the client’s interests) in the comment box.  When caregiver instructions are the same for multiple behaviors, one comment box of the caregiver instruction is sufficient. For other behaviors that the caregiver instruction applies to, indicate so in the comment box. |
| Depression | If the client has a score of 10 or higher, document a discussion about a referral to a healthcare provider or mental health resource. Follow the Guidelines for Referrals. |
| Memory | If the response to the Short-Term Memory question is not consistent with the client’s ability to recall the 3 items in the MMSE as well as other information in the assessment, document the inconsistency in the applicable Comment box. |
| MMSE | Administer the MMSE to each client:   * At the Initial assessment. * Whenever the period of time from the last MMSE equals 12 or more months. * When a significant change assessment is completed because of a reported change in cognition.   The MMSE may be omitted when the client is under 18, has moderate to profound intellectual disability, has severe delirium/dementia, or is non-verbal. Use the *Other Factors* Comments box to document client characteristics that may affect the score. |
| Suicide | If the client answers “yes” to any of the questions, discuss a referral to an appropriate healthcare provider; follow the Guidelines for Referrals. If the client has a plan, the means to carry it out and a time planned, contact the local mental health professional or crisis clinic. |
| Supervision of providers | If the client is unable to always supervise the in-home provider, identify an informal support person (not a paid caregiver) who can provide supervision. Only clients who are coded as “Independent” or “Difficulty in New Situations” may supervise their paid provider. When no informal support can be identified to meet this need, document in the comment box how monitoring of the case will occur. In order to increase contact, place the client on targeted case management and consider using more than one IP or an agency caregiver. |
| Emergency plan (Evacuation/Back-up Plan) | **Evacuation plan**   * The intent of an evacuation plan is to document how the client and/or providers would respond to emergency situations. * Discuss evacuation/emergency planning with the client and document the plan by selecting standard language on the Safety Screen under “In-home evacuation plan.” * Use the Comment boxes to add client-specific information if necessary.   **Back-up plan of care**   * If lack of immediate care would pose a serious threat to the health and welfare of the client, include a backup plan. Examples of clients who fall into this category are those who use devices that require electricity or constant monitoring; or clients who require continuous monitoring for a medical condition. * Discuss the backup plan with the client and backup caregiver. * CARE Web: Document in the Client Safety screen using the selections under “Caregiver instruction(s) and safety concerns.” Use the Comments box to add client-specific information if necessary. * Identify the back-up caregiver on the *Collateral Contact* screen. |
| Potential for abuse and neglect | Follow APS guidelines. If there are no indicators of abuse or neglect, select “None observed or reported” in the Legal Issues section on the Safety screen. |
| Alcohol/Substance abuse CAGE interviews | Follow the guidelines on the Substance Use screen and the Guidelines for Referrals. |
| Explanation of inconsistencies | Use Comment boxes to explain inconsistencies or conflicting information in relevant screens.  For example, when one ADL is scored Independent, and another, scored Total Dependent, Comment boxes must document explanation. |
| ADL and IADL screens | Use the bucket selections to provide a clear description of the client’s strengths, preferences, limitations, and caregiver instructions. Use the Comment box, if necessary, to provide specific instructions to the caregiver that are not available in the buckets.  **Status (Looking forward):**  If the client will receive non-ALTSA-paid informal support for any ADL or IADL, the assessor will select Met or Partially Met and identify the amount of support under Assistance Available (Looking Forward), using the chart provided in the *Assessing Status* section or CARE Web Assessor Manual/Help screen. Examples of non-ALTSA-paid informal support are family members, neighbors, Adult Day Care, or Adult Day Health.  **NOTE:** if a Need is documented on the Medical screen that DME or an assistive device might be helpful, please see the Appendix > Bed Rail Policy. |
| Guidelines for Referrals | When a non-mandatory referral is indicated (e.g., Depression score of 10 or more or pain score of four or more, etc.), document a discussion with the client in the Comments box on the appropriate screen. Discussion may consist of providing information sheets developed at the local level for self-referral. If the client requests assistance with a referral, document this in CARE on the corresponding screen[[4]](#footnote-4). Include the date you referred the client and who is responsible to follow through. |
| **CARE PLAN** | |
| Client is eligible for: | Program selected must match services authorized in ProviderOne. For example, if a client is converted from CFC to CFC+COPES, the correct program must be selected in the Care Plan screen and the correct program authorized in the payment system. |
| Necessary Supplemental Accommodation (NSA) | Include an NSA Description, if applicable. This is appropriate if the client has a special need (mental, neurological, physical, or sensory impairment – does not include Limited English Proficiency) that prevents them from getting program benefits in the same way that a person without an impairment would get them.  Indicate and describe the NSA on the 14-443 sent to the PBS through Barcode. |
| Referrals to Nursing Services | If a Critical Indicator is listed on the *Triggered Referral* screen, enter the date a referral was made and the reason for the referral. If a referral was not made, identify why a referral was not necessary. Follow the nursing services policies outlined in the [Chapter 24, Nursing Services](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%2024.docx). |
| Supports screen | * All tasks identified in the Supports Screen must be assigned unless a task is awaiting coordination * Document a schedule when the client has a preferred schedule. Do not identify more hours than what the client is eligible for and what is authorized in the payment system * Unmet tasks are assigned to at least one paid provider. Assign providers using the paid providers search function or “providers from current plan” tab, NOT the contacts or resources tabs * Partially Met tasks are assigned: * to at least one paid provider from the paid providers search or the “providers from current plan” tab, AND * and at least one informal support from the contacts or resources tab * Met tasks are assigned to an informal support only from the contacts or resources tabs |
| Community First Choice (CFC) Services | CFC Services must be included in the client’s plan of care prior to authorization. In addition, the assessment must support the client’s eligibility for CFC.  **Personal Care:**   * Relief Care: Personal care hours may be authorized to an alternate provider. Document a relief care provider in the Collateral Contacts screen and assign tasks in the Supports Screen if a relief care provider is in place. * Nurse Delegation: If nurse delegation is in place, identify Nurse Delegation and IP or Agency as providers in the *Treatments* section of the Medical screen and assign the nurse delegator and paid personal care provider(s) to the task on the *Supports* screen. For medication management, assign the nurse delegator and paid personal care provider(s) on the *Supports* screen. * For treatments, if nurse delegation is not yet in place, identify Nurse Delegation and IP or Agency in the *Treatment*s section as providers and add a comment that the task will be delegated when the provider completes the training. * For medication management, if nurse delegation is not yet in place, state in the Comments box that the task will be delegated when the provider completes the training. * In the meantime, if the treatment/medication management is being performed by an informal provider, identify the informal provider on the *Supports* screen and assign the task. Reassign the task to the delegating nurse and paid provider after the IP and/or agency provider has completed the Nurse Delegation training.   **Skills Acquisition Training:**   * A client may choose to use some of their personal care hours for Skills Acquisition Training (SAT) authorized to an agency provider, IP, or supported living provider. * Document on the ADL or IADL screen who will be providing the SAT and what task the client is wanting training on (e.g. learning to shave with electric razor with non-dominant hand due to stroke on dominant side – this would be listed in the Comments box on the Personal Hygiene screen)   **Back-up Systems:**   * **Personal Emergency Response System (PERS):** select “PERS unit” and/or “PERS installation” from the Walk/Locomotion equipment list. Assign a contracted PERS provider on the *Support* screen. Following LTC chapter [7b, “Community First Choice (CFC),”](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207b.docx) document the client’s eligibility for PERs unit in the *Safety* screen*.* * **Relief Care:** document a relief care provider in the Collateral Contacts screen and assign tasks in the Supports Screen if a relief care provider is in place * **Caregiver Management Training:** document date materials were sent or the web link provided on the CFC screen in CARE. If more than one type of material was issued, choose only one, adding both is not required. * **Community Transition Services (CTS): s**elect “Other” from the Programs list in the *Treatments* section. Describe the type of services or items the CFC CTS funding will be for in the corresponding Comments box. Address in the Care Plan, including assigning a provider on the *Support*s screen when appropriate. See [Chapter 7b](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/) for eligibility criteria and more information. * **CFC state fiscal year (\*SFY) annual limit:** CFC SFY annual limit comprises of purchases/payments for both Assistive Technology (AT) and Skills Acquisition Training (SAT). If items/services are to exceed this limit, an ETR request to the CFC Program Manager is necessary. See [Chapter 7b](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/) for more information. \*SFY is July 1 to June 30. * **Assistive Technology (AT):** Includes add-on services to the basic/standard PERS (e.g. fall detection, GPS, Medication Reminder/Dispenser) and other adaptive/assistive items/devices that will increase an individual’s independence or substitute for human assistance with an ADL, IADL or health-related task. Document in the relevant screen in CARE and select “Assistive Technology” from the corresponding equipment table. Please consult the [CFC Covered AT Items list](https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/CFCO/CFC%20AT%20Covered%20Items%20List.xlsx) to confirm that desired item is approved. See [Chapter 7b](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/) for more information. * **Skills Acquisition Training (SAT):** may be purchased using CFC SFY annual Limit. See [Chapter 7b](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207b.docx) for more information. * **Budget Calculator in CARE:** use to identify, track, and calculate the use of a client’s CFC SFY Annual Limit. This is especially useful and helpful to quickly look at what the client has already used and also if the case is transferred to another case manager. |
| COPES Waiver Services | Waiver services must be included in the client’s plan of care (Assessment Details or Service Summary) prior to authorization. In addition, the assessment must support the client’s eligibility for each service.   * **Environmental Modification**: select environmental modification in the *Environment* section on the Safety screen and describe the project in the comment box. Assign a contracted Environmental Modification provider on the *Supports* screen. * **Skilled Nursing**: select “Skilled Nursing/Waiver” from the Treatments list in the *Treatments* section of the *Medical* screen. Describe the type of skilled care in the Comments box. Assign a provider on the *Supports* screen. * **Client Training**: select “Client Support Training/Waiver” from the Rehab/Restorative Training list in the *Treatment* section of the *Medical* screen. Describe the type of training in the Comments box. Assign a provider on the *Supports* screen. * **Adult Day Health (ADH)**: select “Adult Day Health” from the program list in the *Treatments* section of the *Medical* screen. Assign a provider on the *Supports* Screen. (Status adjustments must be coded in the relevant CARE screens for the assistance with ADLs and IADLs provided by ADH staff while at the ADH) * **Adult Day Care (ADC)**: select “Adult Day Care” from the Programs list in the *Treatments* section of the *Medical* screen. Assign a provider on the *Supports* screen. (Status adjustments must be coded in the relevant CARE screens for the assistance with ADLs and IADLs provided by ADC staff while at the Adult Day Care center) * **Specialized Medical Equipment**: select “Specialized Medical Equipment” from the appropriate equipment table and describe the item in a Comments box for that ADL. Assign a provider on the *Supports* screen. * **Client Transportation**: assign a provider to Transportation need on the *Supports* screen. * **Home-Delivered Meals**\*: assign a provider to Meal Preparation task on the *Supports* screen. Document the hour adjustment in the In-home Adjustments tab on the Care Plan screen and assign the paid provider on the *Supports* screen. * **Wellness Education:** select “Wellness Education Service” from the Program list in the *Treatments* section of the Medical screen and use the provider type “other”. Assign “Smart Source, LLC” as the provider on the *Supports* screen. * **Community Choice Guide (CCG):** select “Community Integration” from the Program list in the *Treatments* section of the *Medical* screen. Document CCG tasks via Pre*-Transition & Sustainability* screen > *Sustainability Goals* screen. Assign the paid provider on the *Supports* screen. * **Community Support:** Goods and Services (available only for individuals moving from a licensed residential setting to in-home):Select “Other” from the Program list in the *Treatments* section of the Medical screen. Describe the Community Support needed in the corresponding Comments box. Assign a provider on the *Supports* screen. |
| Environmental Modifications/  Durable Medical Equipment | Enter the date the Durable Medical Equipment or Environmental Modification is expected to be completed/obtained in the “Act By” field.  The Follow Up screen must include updated detail in the Comment Box of current status/steps taken, related to “Who Acts.” |

### Case File Standards

This section outlines standards for what is required in the electronic case record, record retention, obtaining original documents/signatures, and utilizing the Document Management System in Barcode.

#### HCS Imaging Unit (HIU) and Electronic Case Records (ECR)

HCS IMAGING UNIT is a subset of the Barcode application which was written and is maintained by Economic Services Administration (ESA). HCS IMAGING UNIT manages and stores documents creating an electronic case record known as the ECR eliminating the need for a paper case file. Once a document arrives at the Hub Imaging Unit (HIU) it is scanned and indexed to the appropriate client and assignments based on each office’s set of assignment rules or Assignment Matrix, and then will display as a *Tickle* assignment on the appropriate workers *Barcode To-Do* list.

#### What should be sent to HIU for imaging into ECR?

The following documents that have not been superseded by a more recent version:

* [14-225 Acknowledgement of Services](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=14-225&title=)
* [14-012 DSHS Consent](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=14-012&title=)
* [16-172 Client Rights and Responsibilities](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=16-172&title=)
* (D)POA/Guardianship paperwork and documents, if not submitted previously
* [10-234 Individual with Challenging Support Issues](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=10-234&title=)
* [10-234A Individual with Complex Behaviors](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=10-234&title=)
* [14-534 Specialized Dementia Care Program Eligibility Checklist](https://www.dshs.wa.gov/sites/default/files/forms/pdf/14-534.pdf)
* Residential clients’ Negotiated Care Plan or Negotiated Service Agreement
* Least Restrictive Alternative (LRA) documents
* **Any other critical client information that is needed for continuity OF CARE as determined by CM/SSS and supervisors.** Be mindful of the volume of documents sent for imaging. Send only the critical documents or pages**.**

Medical records including Medical Administration Records (MAR) are NOT required to be scanned into the client’s ECR. If there is something identified in a medical record that is determined to be critical for the ECR and for service continuity, be mindful of the volume of pages sent for imaging. Send only the critical portions of the medical record.

#### Original Signatures and Electronic Transmission

Certain forms require that the original signatures be available in the client’s file. To meet this requirement, the Secretary of State’s Office has certified imaged documents as originals only if documents sent to HIU are as the client originally submitted the item to a DSHS office. Example: If the client returned the original signed document, this original signed document must be sent to the HIU. HIU does have the ability to accept faxed documents directly from clients or providers and these items will be considered “original” documents, but they must be submitted by the client or provider.

If a site has received an electronic transmission, such as fax or PDFs as attachments to e-mails, these will be accepted as originals if the site first prints these items and sends to the HIU to be imaged to the client’s ECR. Electronic records and signatures created are considered original source documents.

#### Organization of Electronic Case Record

Client documents are housed and managed digitally within the Electronic Case Record (ECR), which is part of the Barcode application’s HCS Imaging Unit (HIU). The ECR can be accessed from the Barcode Welcome Screen (select AU search), or from within CARE > Launch Menu (rocket ship icon: ), or, once the client is in view (barcode icon: ). When viewing a client’s ECR, you can search by document type and specify the timeframe (history).

Documents are sent to HIU to be scanned into and associated with the client’s ECR. HIU staff scan each document and identify the type of document based on a list of general categories, assign the document a code from those categories and match the document to the client. The document then runs against a matrix from the site that sent the document to the HIU. This matrix identifies how each document type is to be assigned for each office. A complete list of document codes is available in Barcode and on the HIU SharePoint website.

Training and additional information about HIU and ECR is available at the ALTSA Training Page: (<http://adsaweb.dshs.wa.gov/training/>).

Documents contained in the client’s electronic case record cannot be deleted by the HIU after they have been submitted for imaging unless there are exceptional circumstances (e.g., a client is protected by address confidentiality program).

**Adult Protective Services (APS) documents:** APS documents must never be sent to HIU and should not be included in the ECR. The APS investigator will provide a paper copy to the client’s CM/SSS in order for any appropriate SER documentation to occur and then the CM/SSS must then destroy using a secure destruction method (shred box) according to [Administrative Policy 5.04](http://one.dshs.wa.lcl/Policies/Administrative/DSHS-AP-05-04.pdf). APS maintains paper files and can be contacted to access APS documents on a need to know basis. Please refer to [APS Policy & Procedure](https://apswa.navexone.com/content/?public=true&siteid=1).

#### Frequently Asked Questions about the Electronic Case Record (ECR) and the HCS Imaging Unit (HIU)

* **How will staff receive training to use Barcode and ECRs?**
* Articulate trainings are available to social work, technical and supervisory staff and available at the ALTSA training site: <http://adsaweb.dshs.wa.gov/training>.
* **How will Hub Imaging Unit (HIU) staff assign documents?**
* HIU staff do not assign any work. HIU staff are tasked with imaging documents, identifying the document type/office, and then matching these imaged documents up to existing clients. Once these processes are completed, the HIU system will run all newly received documents against the identified office’s matrix. The matrix is a set of rules for a site that tells HIU how to assign each type of document.
* **What happens to documents that cannot be matched up to a client?**
* Each site has a Mystery Mail view (accessible from your To-Do list) that will display all documents that arrived for your office but could not be matched to a client. If you can identify the matching client to a document found here, you or the HIU can link the document in the system.
* **How will staff be notified of any Barcode/HIU outages?**
* Someone at your site should be signed up for the Barcode Listserv. You will be notified via e-mail problems are occurring in the Barcode application. You can sign up at: <http://listserv.wa.gov/cgi-bin/wa?SUBED1=itd-central-support&A=1> (select “Barcode”).
* **How do I use the two different types of coversheets? (The Social Services Invoice / Receipt Packet Cover and Financial Document Packet Coversheet)**
* The PACKET COVER SHEET - SOCIAL SERVICES ([DSHS Form #02-615](http://forms.dshs.wa.lcl/formDetails.aspx?ID=58946)) is used by the SSS/CM to submit final invoice(s) and/or receipts to HIU for imaging. By using the Social Services packet coversheet, the document will be indexed as an Social Services Receipt, rather than an RX (an RX is a type of financial document). Note: All home care agencies have been informed to include the code SSR when sending letters regarding client’s unpaid participation so these items can be indexed correctly. Staff must ensure receipts have an SSR cover sheet attached.

The PACKET COVER SHEET - FINANCIAL ([DSHS #02-614](https://forms.dshs.wa.lcl/)) is used to keep documents that are of a different type together so they can be indexed as a single document, most often used for NGMA or Overpayment Packets. A document coversheet is not needed if a doctor’s report is being sent to the HIU or just because a document has several pages. Do not mix the dates when using the batch cover sheet. The date on the cover sheet is the date that will be used even if other documents have different dates. The date stamped on the document should be the date received at the office.

* **What should staff do if a client document gets placed in the wrong electronic file?**
* Request an HIU Document fix. From within a client’s ECR, highlight the document that has been indexed incorrectly and select from the dropdown menu “Document Tools” and “Request HIU Doc Fix”; then select the best description of the problem from the dropdown list.
* **Can staff request documents be deleted that have already been sent to the HIU for imaging?**
* No, documents cannot be deleted unless there are exceptional circumstances such as APS or a client protected by address confidentiality.
* **Can I complete assignments for workers in other offices?**
* Only if you also have an account in that office.  Staff may only complete assignments for others if they are sure the other staff person does not need to see the assignment.
* **What is the Department policy on imaging CARE Service Summaries?**
* All versions of the Service Summary should be imaged in the event of a fair hearing request covering the usual record retention period of 6 years. CARE retains past versions of Service Summary in most instances when a new Service Summary is created; however, if changes are made to a Current assessment in the plan of care e.g. change of providers, you will want to send an updated Service Summary to be imaged to the ECR. If the complete Service Summary is sent to imaging and then the client returns the signature page, staff do not need to send the entire Service Summary to HIU again; just the signature page.
* **Should staff include a copy of the drawing and simple sentence that is administered to the client through the MMSE during the CARE assessment?**
* Retaining this document is optional but can be useful to note cognitive changes from one assessment to another. Because this document is also used by CSD, it is coded as a Doctor Request (DR) type document rather than a CARE Case Manager (CAR). The form is generated in CARE to be easily scanned to the correct ECR.
* **I have client enrolled with the Address Confidentiality Program (ACP).  How will staff record the client’s physical address?**
* If your client is enrolled in ACP, the actual residential address must not be maintained in Barcode or in CARE. CRM/CM/SSS staff who need to visit the client will maintain residential addresses in a locked location within the office and this information will only be given to providers on a need-to-know basis. A substitute mailing address (given by the ACP program) is the only address to be maintained in electronic records. The client may request communication occur only in a preferred way such as e-mail, a particular phone number or contact time. This information must not be maintained in the electronic record.
* **What is the policy concerning the storage of translated documents in the client’s ECR?**
* When sending documents to the HIU, staff must send the English and translated versions together with the exception of the CARE documents listed below. These documents do not have to be sent in English and may be sent in the translated version only:
* Assessment details
* Care Results
* Planned Action Notices
* Personal Care Results (PCR) or Personal Care Results Comparison (PCRC) – In-home and Residential
* Service Summary generated by a new CARE assessment

NOTE: If changes are made to a Current assessment in the plan of care e.g. change of providers, there may not be a historical record, so this document must be sent in English along with the translation to HIU. While the translated version of documents may be signed by the client who is LEP, the English versions of all documents that require client signature are the official versions and must be signed by the LEP client.

**For Braille Transcription:**

1. See [Chapter 15A/B](https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual) for complete instructions for obtaining Braille Transcription
2. The ADA/LEP Program Manager will send an e-mail to the field staff who requested the translation. The SSS/CM will send this e-mail to HIU for imaging. The e-mail will include:

* A statement that the text was transcribed into Braille and sent to the client;
* Confirm the date the Braille notice was sent by postal mail with USPS tracking number to the client;
* Whether or not the notice was returned as undeliverable by the post office and, if so, the date of the notice
* **Where can staff get additional HIU supplies (envelopes, completed stamps)?**
* **For HCS staff:** Templates to place the envelope orders have been transferred to your sites. Staff should be able to order these through the normal process. HCS sites will reorder any “Completed” stamps needed for staff.

**For AAA Staff:**  We are not able to transfer templates to your areas for reorder. Sites needing more envelopes or “Completed” stamps\* must send an e-mail to Melanie McGuire, [melanie.mcguire@dshs.wa.gov](mailto:McguiMA@dshs.wa.gov). The subject line of your E-mail should read: ATTN: HIU Supplies/Barcode Site # (#= your Barcode site number). Melanie will be placing orders on the first of each month.

**\***Please continue ordering “Completed” stamps through your sites supply channels if they are available. Remember stamps must be in black ink.

### Forms and Brochures

|  |  |
| --- | --- |
| **FORM/BROCHURE TITLE** | **REQUIREMENTS** |
| Medicaid and Long-Term Care Services for Adults Brochure  ([DSHS #22-619](https://www.dshs.wa.gov/sites/default/files/publications/documents/22-619.pdf)) | Review with the client at the Initial assessment. |
| [Voter Registration (ABVR) forms](http://www.sos.wa.gov/elections/abvr/forms.aspx) | At least annually, during in-person visits, continue to ask the client if they would like to register to vote and if they need assistance with filling out the form. Use [Agency Based Voter Registration (ABVR)](http://www.sos.wa.gov/elections/abvr/forms.aspx) forms and complete the voter registration screen in CARE. |
| Estate Recovery Information | Review ([Estate Recovery For Medical Services Paid For By The State,](https://www.washingtonlawhelp.org/resource/estate-recovery-for-medical-services-paid-for?ref=gWAVF) from the [NW Justice website](https://www.washingtonlawhelp.org/)) with the client at the Initial assessment. |
| Self-Directed Care ([DSHS Form #22-388](https://www.dshs.wa.gov/sites/default/files/publications/documents/22-388.pdf)) | Review with the client at the Initial assessment or when SDC is first authorized. |
| Client Rights and Responsibilities  ([DSHS 16-172](https://www.dshs.wa.gov/sites/default/files/forms/pdf/16-172.pdf))  \**Available in CARE* | Review with the client at the initial (or at the Significant Change/Annual if the form has not been signed). Have the client sign two copies; one copy for the client’s file and leave one copy with the client. If an updated version of a signed form exists, have the client sign the updated form. |
| Acknowledgement of Services  ([DSHS 14-225](http://forms.dshs.wa.lcl/formDetails.aspx?ID=7215))  \**Available in CARE* | Review with the client who is considering a waiver service or the Community First Choice (CFC) program. When a waiver or CFC program has been chosen, have the client sign two copies; one for the client’s file and leave one copy signed also by the case manager, with the client. If an updated version of a signed form exists, have the client sign the updated form. |
| DSHS Notice of Privacy Practices  ([DSHS 03-387](http://forms.dshs.wa.lcl/formDetails.aspx?ID=3583)) | Review the first two pages with the client at the initial assessment. Do not print or provide the third page which indicates a signature is required, because it is not. |
| Consent Form ([DSHS 14-012](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=14-012&title=))  *\*Available in CARE* | Prior to gathering information from collateral contacts or sharing information with others, you must have the client review and sign the consent form annually. |
| FDA Bed Rails Brochure  [“A Guide to Bed Safety”](http://www.fda.gov/downloads/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/HospitalBeds/ucm125857.pdf) | Provide to the client, family, and personal care providers, when a request for new bed rails is made. Include [Translated Versions](http://intra.altsa.dshs.wa.gov/hcs/translations/BedSafetyTranslations.htm) for LEP recipients as needed. |
| Notice and Consent of Communication via Text or Unencrypted Email ([DSHS #27-156](https://www.dshs.wa.gov/office-of-the-secretary/forms)) | Have client sign when they indicate they (client) would like to receive communication by text messaging or email, via unencrypted email. Place signed copy in client’s ECR. |

### Assessment Location Grid

| **TO** | **From hospital…[[5]](#footnote-5)** | **From SNF…** | **From residential…** | **From in-home…** |
| --- | --- | --- | --- | --- |
| *Hospital (Rehab/ Transitional Care units)* | HCS will coordinate with the discharge planner and assess within 7 days of referral or when ready to discharge to the community, whichever is earlier. | N/A | N/A | N/A |
| *In-home* | * HCS performs initial assessments for Medicaid applicants requesting long-term care services (except for Asian Counseling and Referral Service (ACRS) and Chinese Information Service Center (CISC) clients). * AAA/DDA will update the care plan or perform a Significant Change assessment for existing in-home clients who are returning home within 30 days of their hospital admit. The AAA will transfer the case to HCS if the client’s out-of-home hospital stay exceeds 30 days. | * HCS performs an initial assessment for Medicaid conversions; * HCS/AAA/DDA performs a Significant Change assessment if there has been a significant change in an existing client’s condition. * The AAA may transfer the case to HCS if an existing in-home client’s out of home stay exceeds 30 days. AAA and HCS may negotiate whether to transfer the client if it appears the client will return home within a reasonable timeframe. Continuous Hospital and SNF days are totaled to determine days out of the home. | HCS performs an initial assessment (for new clients) or a Significant Change assessment and/or updates the *Care Plan* screen to reflect the change in setting. | HCS performs initial assessments for Medicaid applicants requesting in-home long-term care services (except for Asian Counseling and Referral Service (ACRS) and Chinese Information Service Center (CISC) clients). |
| *Residential* | * HCS performs initial assessments for Medicaid applicants requesting long-term care services. HCS informs the client of choices of settings. * For existing clients, HCS/DDA will perform an Interim or Significant Change assessment, if needed. | When clients are ready for discharge, HCS performs an initial assessment for Medicaid conversions and a Significant Change assessment for existing clients. | HCS/DDA updates the *Care Plan* screen to reflect changes if it is a different setting (e.g. AFH to AL). | AAA/DDA shall make any changes to the plan and/or perform an in-person assessment if the client’s condition has changed since the last assessment. |
| *SNF* | HCS will review the record and use the NFLOC screen to determine that the resident meets institutional status per [WAC 388-106-0355](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0355) for:   * MPC and Chore clients * Medicaid recipients/applicants (clients who are receiving Medicaid, but not home and community programs) * Individuals who require a Level II PASRR but are not otherwise receiving DSHS services (regardless of payor source); and * Clients who are requesting or need [Alien Emergency Medical](http://adsaweb.dshs.wa.gov/docufind/LTCManual/NFCare/alien.htm). * Clients who are requesting [State-funded Long Term Care for Non-Citizens (LTC-NC)](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%25207g.doc&wdOrigin=BROWSELINK) program;   **Note:** The NFLOC screen may be completed after admission to the nursing facility. | * For residents who, after being admitted, convert to Medicaid payment, HCS will review the record to determine that the resident meets institutional status per [WAC 388-106-0355](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0355) and notify financial using the [14-443](http://asd.dshs.wa.gov/forms/wordforms/adobe/14_443.pdf)and complete the NFLOC screen. The client must have first paid privately to be considered a conversion. * For a client on the N-Track (MAGI): If the client is covered by the AH MCO rehab or skilled nursing benefit, then no NFLOC is required. * If a MAGI client is not admitting to the nursing facility under a benefit covered by the MCO, enrolls in an AH MCO after date of admit, orif the client’s rehab or skilled nursing benefit is ending (or has ended) with the AH MCO, the facility will notify HCS for an intake. HCS must determine NFLOC and notify HCA by completing form 15-442 in Barcode. * No assessment is required when the client is moving from one facility to another. | For CFC+COPES clients, HCS updates the care plan to reflect the change in setting.  For MPC clients HCS performs a Significant Change assessment or completes the NFLOC screen prior to admit. The client’s medical chart, nursing assistant notes, and staff interviews and other records can be used to supplement interviews with the client to assess activities of daily living, cognition, etc. to perform the NFLOC assessment. | * For CFC+COPES clients, the AAA updates the care plan to reflect the change in setting. * For MPC clients and Chore clients who don’t already meet NFLOC, the AAA/DDA performs a Significant Change assessment or completes the NFLOC screen prior to move to SNF. * If the client is to remain out of the home less than 30 days, the AAA/DDA maintains the case. * If the AAA/DDA maintains the case, pursue MIIE. * For new Medicaid applicants, HCS explains all options available prior to admit. If NF is chosen, HCS completes a NFLOC.   \*While HCS approves moves to a SNF, all CFC and CFC+COPES clients are eligible for (and may choose) to reside in a SNF. |

### LTSS ETR Types and Approval Authority

**NOTE:** All ETRs sent to HQ for approval must have been processed to HQ by a Field Approver first.

| ETR Category | ETR Type | Waiver Type | Outcome Value  Rate ($), Unit (Each), Quantity (?) | Approval Authority |
| --- | --- | --- | --- | --- |
| Medicaid Personal Care (MPC)  Choose MCO only when MCO has agreed/approved to fund the Wraparound Support services | Personal Care: In Home | N/A | Hours | HQ Approval by ETR Committee |
| Personal Care: Residential | N/A | Rate |
| MCO: Hours (In-Home) | N/A | Hours |
| MCO: Rate (Residential) | N/A | Rate |
| CFC Personal Care  Choose MCO only when MCO has agreed/approved to fund the Wraparound Support services | Personal Care: In Home | N/A | Hours | HQ Approval by ETR Committee |
| Personal Care: Residential | N/A | Rate |
| Personal Care: Limitation Extension | N/A | Hours |
| MCO: Hours | N/A | Hours |
| MCO: Rate | N/A | Rate |
| New Freedom Personal Care | Personal Care : In Home | N/A | Hours | HQ Approval by ETR Committee |
| Personal Care: Limitation Extension | N/A | Hours |
| Residential Support Waiver Personal Care | Personal Care: Residential | RSW | Rate | HQ Approval by ETR Committee |
| Waiver Services  (Ancillary Services for COPES recipients) | Environmental Modifications | COPES | Rate, Units, Quantity | Field Approval (AAA or Regional) |
| Special Medical Equip and Supplies | COPES | Rate, Units, Quantity |
| Transportation Services | COPES | Rate, Units, Quantity |
| Skilled Nursing: Rate or Hours | COPES | Rate or Hours (treat Hours as RN visits) | HQ Approval by Skilled Nursing Program Manager |
| Client Training: Rate or Hours | COPES | Rate or Hours | Field Approval (AAA or Regional) |
| CFC Services | Community Transition Services | N/A | Rate, Units, Quantity | HQ Approval by CFC Program Manager |
| Exceed CFC Annual Service Limit | N/A | Rate, Units, Quantity |
| State Only | Chore Hours (to exceed CARE) | N/A | Hours | HQ Approval by ETR Committee |
| Chore Spouse Provider | N/A | N/A | HQ Approval by Chore Program Manager |
| Residential Discharge Allowance | N/A | Rate ($), Unit (Each), Quantity (1) | Field Approval (Regional) |
| PDN (Private Duty Nursing) | Private Duty Nursing >16 hrs/day | N/A | Hours | HQ Approval by PDN Program Manager |
| Personal Care In-Home | N/A | Hours | HQ Approval by ETR Committee HQ/ PDN Program Manager |
| Bedhold (initiated by Bedhold Unit only) | Bedhold-not hosp or SNF (associated assessment is not required) | N/A | NA | HQ Approval by Bed Hold Program Manager |
| Social Leave | AFH/BH Leave >18 days/yr | N/A | NA | Field Approval (Regional) |
| NH Leave >18 days/yr | N/A | NA |
| Other Use for Assistive Technology (contact Linda Garcia), or Financial | Other  (Associated assessment is not required) | N/A | All fields enabled | Varies |
| RCL –Personal Care | Personal Care In-Home | N/A | Hours | HQ Approval by ETR Committee |
| Personal Care: Residential | N/A | Rate |
| Personal Care: Limitation Extension | N/A | Hours |
| RCL/WA Roads-Services | Client Training: Rate or Hours | N/A | Hours | Field Approval (AAA or Regional) |
| Community Integration (e.g. CCG) | N/A | Rate, Units, Quantity |
| Community Transition Services | N/A | Rate, Units, Quantity |
| Environmental Modifications | N/A | Rate, Units, Quantity |
| Skilled Nursing: Hours (Treat as RN visits) | N/A | Hours | HQ Approval by Skilled Nursing Program Manager |
| Skilled Nursing: Rate | N/A | Rate |
| Special Medical Equip and Supplies | N/A | Rate, Units, Quantity | Field Approval (AAA or Regional) |
| Transportation Services | N/A | Rate, Units, Quantity |

## Attachments

### Guide to Electronic Signatures



### Voice Signature Script



### Service Summary Signatures



### ETR FAQ for Providers



### ETR FAQ for Hospitals



### CFC Care Planning Advocate Flow Chart



1. If the client is experiencing homelessness, select “Homeless” as the Residence Type. Document known special instructions in the Comments box to assist staff in successfully contacting the client. [↑](#footnote-ref-1)
2. Rarely, but sometimes, the information may be incorrect in ACES. When this happens, the CARE record still needs to match ACES to link correctly. When ACES information is incorrect, the client should work with their financial worker to correct it. [↑](#footnote-ref-2)
3. Durable Power of Attorney (DPOA) and Guardian are examples of duly appointed representatives. A DPOA (as a type of Power of Attorney) is the only one that can be used when the client becomes incapacitated. A copy of the relevant POA document is to be maintained in the electronic case record as needed and updated as required. A legally appointed guardian must have guardianship papers and an unexpired copy must be kept in the electronic case record. [↑](#footnote-ref-3)
4. APS, Suicide, and Skin Observation Protocol (SOP) are mandatory referrals. [↑](#footnote-ref-4)
5. HCS must also complete assessments prior to patients being discharged from Eastern or Western State Hospital. [↑](#footnote-ref-5)